

Health Care Financing Grants and Contracts Reports

Medicaid Nursing Home
Reimbursement: New York, Illinois,
California Case Studies

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Health Care Financing Grants and Contracts Reports

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Medicaid Nursing Home Reimbursement:
New York, Illinois, California Case Studies

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Table of Contents

	<u>Page</u>
I. Introduction	1
A. Overview	1
B. Reimbursement Issues	5
II. The Industry, The Reimbursement System, and The State	33
A. The Nursing Home Industry	33
B. Medicaid Reimbursement	38
III. The Politics of Reimbursement: 1974-1977	47
A. 1974: Scandals and Allegations	47
B. 1975: Investigations, Increased Regulations and Revised Capital Reimbursement	49
C. 1976: Fiscal Crisis, Rate Freeze, Fair Rental Value, Quality Ratings, and Boycott	56
D. 1977: Reassessment and Task Force	74
E. 1974-1977: Observations	85
IV. Trends in New York's Reimbursement System	88
A. Capital Costs	92
B. Operating Costs	96
Footnotes	98

I. Introduction

Since its inception, the New York Medicaid program has led the country in expenditures for long term care. In 1977, for example, New York spent \$1.28 billion on nursing homes, more than the total Medicaid budgets for any state in the country with the exception of California.¹ New York accounted for 28 percent of the nation's total expenditures for SNFs and 20 percent for ICFs.² The scale of the program alone makes it important for study and evaluation. New York's effect on Medicaid, however, is larger than its percentage of national expenditures. Other states are greatly influenced by the New York experience, its achievements and scandals; its special studies, recommendations and solutions; its policies, procedures and administration.³

A. Overview

This paper examines and analyzes the changes in reimbursement policy that occurred within New York's Medicaid program from 1974 through 1977. This was a particularly tumultuous period punctuated by scandals and a fiscal crisis. The scandals began in September, 1974, with a New York Times series on the nursing home industry. The series became an extended exposé which lasted several years and focused on four areas: the quality of care in the homes, fraud and abuse, inappropriate political intervention by elected officials, and some very lucrative loopholes in the capital portion of the reimbursement system. The press coverage prompted the creation of a large number of investigations by state, local and federal agencies. The two most influential of these were the Temporary State Committee on Livings Costs and the Economy (1972-1975) and the Moreland Act Commission (1975-1976). Both of these state legislative committees held hearings, issued reports and made legislative recommendations. The seven-volume report published by the Moreland Act

Commission in 1976 has become a standard reference on state policy towards nursing homes.

Many of these committees' recommendations were adopted into legislation. They covered the way the state regulated the quality of care, protected patient rights and property, controlled nursing home operators and monitored and punished fraud. The effect that the scandals and investigations had on the reimbursement methodology, however, was minimal. This is not surprising since the major flaw of the system was that it encouraged fraud (the result of combining payment based on costs with a failure to audit the homes, the absence of penalties for overstating costs and a lack of uniform accounting). One significant methodological change, however, that developed from the scandals was the "fair rental value" (FRV) system for reimbursing capital. Even FRV, however, was not solely the product of the scandals. Implemented in 1976, FRV was billed as a new solution to a number of capital reimbursement problems, particularly the artificial escalation of property costs through "trafficking"--the rapid sale and resale of a nursing home by owners. In fact, FRV was a close variation of a portion of the payment mechanism it replaced. The methodology employed immediately prior to FRV^{*} had frozen capital reimbursement rates for homes in operation prior to March, 1975 and applied a different, more stringent payment method to homes built and operated after March, 1975. FRV slightly modified the new more stringent method and applied it to both established and new proprietary homes.

This does not mean that on the whole the reimbursement methodology was unchanged during the 1974-1977 period, but simply that the scandals were not the impetus for change. Indeed, during this three-year period, there were three different methods for reimbursing operating costs and four methods for

* The methodology employed immediately prior to FRV had been adopted in March, 1975.

capital costs. Two factors independent of the scandals contributed to the continual adoption of new payment techniques. The first was an incremental response by the state to correct what different state agencies recognized as an increasingly unwieldy and expensive reimbursement system. The state had adopted a cost based reimbursement approach in 1967. From 1967 to 1974, the state's major policy objectives were to increase the bed supply and improve the quality of the homes. Cost containment was a secondary concern. Thus, although the homes had rapidly discovered loopholes in the cost based system implemented in 1967 and although the state responded with continual modifications and specific limitations, the state still endorsed a cost based approach as the means of raising quality and meeting the high costs of operating in New York. The end result of all of this was a very complicated and costly payment system--replete with a large number of disallowances, minimums and maximums, special exceptions and pass throughs. Property reimbursement was particularly complex. By 1974, homes were permitted to choose from three different methods for reimbursing property. Owners and operators naturally selected the most profitable method. The move to change capital reimbursement was formally initiated by the chairman of the Medicaid Reimbursement Committee of the Public Health Council in 1972 and finally culminated in the adoption of a new system in March, 1975. This change in policy also signaled a change in Medicaid objectives: cost containment had become a major goal.

New York pursued this goal slowly and incrementally until 1976 when the state's fiscal crisis forced more rapid change. Faced with a \$900 million deficit, New York was forced to cut back on many services in many programs. For nursing homes, this meant first a freeze in the Medicaid

rates and then the adoption of a less lucrative payment mechanism. Capital was reimbursed according to each home's Fair Rental Value. Operating costs were linked to a quality rating system applied to the cost experience of peer groups of homes. The higher the rating, the higher the reimbursement ceiling. The 1976 rates were announced in October and made retroactive to January. In most instances, the rates were the same or lower than the 1975 rates. The industry was outraged. The rate freeze had created difficulties for many homes to cover costs, honor union contracts, and meet their debt obligations. The new retroactive 1976 rates, it was felt, would exacerbate these problems. In November, the New York City Metropolitan Nursing Home Association announced a Medicaid boycott to protest the rates but the boycott quickly folded under the threat of a state anti-trust proceedings.

In 1977, the state convened a special executive legislative task force to examine the reimbursement system and recommend change. Because the state's fiscal situation had improved and because a large number of individuals and interests were upset with the payment methodology, there was strong sentiment among most of the task force participants to alter the more restrictive aspects of the reimbursement system and pay the homes more. As a result, Fair Rental Value was abandoned, the quality rating system was simplified and the rates increased.

B. Reimbursement Issues

The changes and refinements of New York's reimbursement policy during the 1974-1977 period can be understood as a broader attempt by the state to define what type of nursing home industry they wanted to have provide care to Medicaid patient. In light of the scandals there were disputes over the roles that proprietary and voluntary homes should play, the type of operators that should run the homes, the amount of profit that should be legitimately earned by the homes, the treatment of fraud, the relationship between quality of care and reimbursement, etc. As political consensus developed and directions became evident, the state employed a variety of policy devices to meet those ends.

Reimbursement as a policy device is limited. For example, reimbursement techniques cannot assure that patients will receive the appropriate care or that the quality of care delivered is satisfactory. Reimbursement methods can, however, minimize both property and operating costs and reward or punish homes for their allocation and use of resources.

Within this more limited scope, New York grappled with five reimbursement issues during the study period:

1. How should the value of nursing home property be determined?
2. How should the cost of purchasing the home be reimbursed?
3. Should property costs for similar homes be treated differently because of different ownership arrangements (e.g., leased or owned property) or ownership histories (i.e., the sales and leasing history of a facility)?
4. How can the reimbursement of operating costs encourage efficiency?
5. How can reimbursement be linked to the quality of care provided by the home?

Rather than offer the state's answers to these questions, we will begin by setting forth the available options.⁴ We shall devote a large part of

this discussion to capital costs because this area has been one of the most politically sensitive and one of the least understood reimbursement issues in the Medicaid program.

1. How should the value of nursing home property be determined?

Under the cost related system, the state will pay a portion of the homes' property costs (a percentage normally determined by the ratio of Medicaid patient days to total patient days subject to a minimum occupancy limitation). In determining what those property costs are the state may choose from five basic approaches:

- Historic Costs are the costs of constructing the facility when it was first built or renovated. Given the long run inflationary trends over the past forty years, this is the least expensive basis for reimbursement. It freezes the value of the home and does not recognize appreciation in the market value of the facility or the land that it is on. The major shortcoming with historic costs is that it fails to recognize any appreciation in the value of the land or building. Thus, over time, the facility becomes a less and less attractive investment relative to other investment opportunities. It therefore may encourage deterioration of the physical stock and a reduction in the bed supply. On the other hand, since most states using historic costs consider renovation as if it were a new home, (i.e., the actual or historic costs and associated interest expenses are reimbursed over the life of the renovation) then this becomes the only way an owner can hold onto his home and update the value of his facility. Thus, if the rate of depreciation relative to the useful life of the renovation is significantly greater than the same ratio for the facility as a whole, then historic costs might encourage renovation even when renovation was unnecessary.

- Replacement Costs are an estimate of the cost of rebuilding the home, or put more technically, an attempt to measure society's current opportunity costs for diverting resources into the construction of a home. While a more accurate measure of society's costs than historic costs, reimbursement based on replacement cost may be too high, that is, higher if the owner derives returns because of tax benefits, the private pay patient subsidies of Medicaid capital payments, the market value of the home is less than its replacement value and/or the owner is able to reap other hidden profits from the home. Both Minnesota and Illinois had briefly considered using this approach but abandoned it when it became apparent how expensive the use of replacement costs would be.

- The Income Value approach assumes different occupancy levels, payment rates, and cost in order to determine "the present worth of the net income it (the facility) will produce during the remainder of its economic life."⁵ As Richard Ratcliff has observed, there are serious conceptual and methodological problems with this approach;⁶ even if there were none, the application of the income approach to nursing homes will reflect the major role of the Medicaid program. The income approach basically would inform that state what the value of the home is given the existing state rates and projected increases in those Medicaid rates. In other words, as the percentage of Medicaid patients to all patients increases, the income method shows that the value of the home would be whatever the state thought it was.

- Market Value is the price a home will bring on the private market. Under competitive conditions, the market price closely approximates society's opportunity costs. The nursing home market, however, does not meet those conditions because the state controls the supply of homes through its certificate of need program and Medicaid functionally guarantees a rate

and high occupancy. Since the market value is heavily influenced by the current and potential income of a piece of property as well as the property's likely rate of appreciation, and since Medicaid controls both of these factors, then Medicaid rates effectively set the market value of the home. If Medicaid were to pay whatever the "private market" dictated, there would be no effective limit to the cost of nursing homes. The state can also use independent appraisers as a proxy for private transactions. Unless these appraisers recognize constraints independent of an individual facility (e.g., the rate of appreciation for similar non-nursing home commercial property such as apartment houses) they will not be able to place a limit on the price.

- Imputed Value is the price the state establishes for the home independent of the home's actual cost experience. It can be, as in Illinois, the average cost per bed adjusted by age and location of the facility. It can be, as New York had once attempted for homes without historic records, the cost of comparable homes. Or, it can be an arbitrary figure.

The advantage of this approach is that it frees the state from monitoring the financial behavior of the homes, ruling on the validity of transactions, recalculating values, etc. It also increases the amount of control the state has. Instead of relying upon the owners to set the reimbursement rate--as is the case with other methods--here the state places a bid for the service of the home's capital.

The primary problem with this approach is the methodology for deriving the imputed value. If it is low relative to the cost of building and maintaining a code compliant facility, the state may find over time that its bed supply has dwindled and that the bed stock has physically deteriorated. On the other

hand, if the imputed value is well above the cost of a code compliant facility, the state may be encouraging the growth of more beds than it needs, the building of homes more lavish than the state desires, or providing owners with additional and unnecessary bonuses, profits in excess of what was needed to bring the homes into production.

2. How should the cost of purchasing the home be reimbursed?

Regardless of the method of assessing the value of a home, cost-based reimbursement systems require the recognition of the cost of money to build and/or buy the facility. The policy problems the state faces are highlighted by the costs an owner incurs and the fact that those costs are inappropriate reimbursement standards.

a. The Owner's Capital Costs.

An owner's capital costs consist of his mortgage payments and a return on his personal investment. Mortgage payments are a function of the principal borrowed, the interest rate agreed upon and the length of the mortgage. For any given sum of money, if the interest rate is increased or the length of the mortgage shortened, then the payments required to amortize the loan (or pay off the principal) are increased. On the other hand, if the interest rate is reduced or the length of the mortgage increased, the mortgage payments are reduced.

Most mortgages are level payment, that is, the periodic payments remain the same, but the portion of the payment attributable to principal and interest varies. Initially, a mortgage is almost entirely interest payments. As time goes on, the proportion of the payment allocated for amortizing the loan increases.

The actual cost of retiring the loan is one component of the payment for the services of capital. Because of the treatment of depreciation by the tax system, that payment is effectively increased or decreased if depreciation is greater than or less than amortization. This occurs because, unlike interest expenses which are tax deductible, amortization cannot be claimed as tax deduction. Instead, the owner deducts depreciation or an imputed portion of the building that is supposedly being used up each year. The depreciated amount is limited by the depreciation techniques that the federal and state tax offices will recognize. When depreciation is greater than amortization (as is normally the case in the first years of a mortgage) the difference between the two acts to shelter other revenues (literally hide them from taxes). When amortization is greater than depreciation, then actual business expenses exceed that which can be claimed for taxes. In this case, the owner will usually refinance in order to start the process all over again for the new loan (which would be used to pay off the old mortgage and realize some of the appreciation on the home) The new loan would have low amortization, high interest payments and depreciation in excess of amortization. Refinancing assumes first that home's revenues are sufficient to support the new loan (which may not be the case if interest rates on the new loan are higher than the existing mortgage) and second, that banks and lending institutions are willing to deal with the home. Instead of refinancing, the owner could also opt to sell his property.

The other component of the owner's capital cost is the cost of investing his own capital in the home. This can also be thought of as the return he could receive if he invested his money elsewhere. The return on investment is often a function of the risk assumed by the investor, that is, the higher the risk, the greater the return. In assessing the risk of an investment in a nursing home, an owner would recognize that "normal" risks associated with competitive conditions are absent. The state, for example, often controls the supply of the homes, their location, and even the character of their owners through its licensing and certificate of need agencies. The state guarantees a rate and provides a disproportionate amount of the patients. The state, in short, eliminates or minimizes the competitive forces that private firms usually must confront, thereby minimizing the risk. On the other hand, nursing homes are susceptible to rapid and unexpected changes in codes, regulations and reimbursement procedures. State fiscal problems, Medicaid scandals concerning non-nursing home providers, improprieties by a single nursing home operator in or outside of the state, can trigger a regulatory crackdown. The politically volatile position of the home, therefore, increases the risks of being a nursing home operator. The owner must weigh the economic and political risks and determine if the Medicaid reimbursement system provides an adequate return. If it does not, he will attempt to minimize his personal investment--by whatever means are available--and rely upon payment for interest expenses to provide the holder of the mortgage with a necessary return.

b. The State's Payment Options

The state's reimbursement for property costs, however, cannot be based solely (or some might argue even partially) on the owner's costs. If the owner's costs determined state payments, we might expect that owners would get a mortgage with very short terms (two or three years), pay off the facility, continually refinance it, keep the borrowed money and let the state repay the loans. There would be no incentive to seek out low interest rates. In fact, owners could borrow from themselves at extremely high rates. Further, when an owner's costs are the sole standard for reimbursement, there would be no ceiling on the selling price of a home.

Given these possible outcomes, the state must develop its own standards for reimbursing the cost of purchasing a nursing home. This entails defining the useful life of a home and acceptable interest rates and expenses, deciding whether funding of depreciation payments in excess of amortization should be required and who should do the funding, and determining an adequate return on owner investment.

c. The Facility's Useful Life

The useful life of a building recognizes a number of limiting factors: physical, technological and regulatory. In an unchanging world, a building which was not maintained would physically deteriorate with age and use. The physical life of a building is therefore the first definition of useful life, for it sets the limits for all other definitions. For example,

in a world of change, a building may be physically sound but technologically obsolete (e.g., its construction or fixtures are functional but antiquated) or out of compliance with government codes and requirements (e.g., the Medicaid square feet per patient requirement was five feet beyond what a home had). Neither technological nor "code" obsolescence, however, preclude using the building. That would not be the case if the roof leaked, wooden support beams were cracked and rotten, the electrical wiring was frayed and the sewage pipes were clogged and busted.

From the state's perspective, it is important to have Medicaid's payments for property coincide with the building's physical, technological and code compliant life.* The life of the building determines the rate of depreciation. Assuming straight line depreciation (an equal amount depreciation for each year of the building's life), a 20 year life would mean that a home could depreciate 5 percent of the value of the building each year while a 40 year life permits only two and a half percent depreciation. Because most states pay depreciation (rather than amortization) and interest, it follows that as the life of the building increases, Medicaid's yearly property payments decrease, a clearly desirable goal for the state. If the state assigns the home a life well beyond its actual useful life, however, it forces the owner to continually refinance his home in order to keep his amortization payments equal to or less than his depreciation allowance. Regardless of the number of times an owner refinances, if the state assigns an unreasonably long useful life, the building will have been physically used up before the state finishes paying for its share of the property costs.

* The composite life could be thought of as either (1) the shortest of the physical, technological or code compliant life, or (2) the expected duration for which the physical structure should be able to be modernized and kept code compliant.

On the other hand, if the state sets the useful life too low, its Medicaid payments will be unnecessarily high and the owner will be rewarded with an asset which has been paid off and which can still be used as collateral for loans for non-Medicaid related purposes.

Most states which imputed useful lives for nursing homes in 1978 used the guidelines recommended by the American Hospital Association (AHA), Chart of Accounts for Hospitals and the IRS, "Bulletin F."⁷ AHA recommended a 40 year useful life. The IRS recommended for comparable buildings (and depending upon whether the construction was good, average or cheap) useful lives ranging from forty to thirty-three and one third years. Normally, renovation was treated as a "new home" with the American Hospital Association guidelines for depreciation used to establish the useful lives of such partial installments as a new furnace or plumbing.

d. Interest Rates and Expenses

Interest expenses are a function of the rate of interest and the amount of the loan. It is to the state's advantage to minimize both factors. If the state's allowable limits are below market rates, however, new investments in nursing homes will be discouraged and established firms may be forced to close down. The question then is how to arrive at the least expensive arrangement which will neither adversely affect the state's desired bed supply nor reimburse owners more than is necessary.

Interest rates are a function of "risk free" loans, prime rates, the nature of the lending institution, the credit worthiness of the borrower and the collateral or security used for the loan.

Risk free loans are loans which are as secure as the U.S. government, in other words, they are loans which if defaulted would probably signal a collapse of the general economy. These are usually long term U.S. government bonds ("loans" the government secures from the purchasers of the bonds),

the interest rates "charged" are usually the lowest in the money market because the return is guaranteed. These bonds set the minimum interest rate. All other loans will have a higher risk associated with them (i.e., a lower probability that they will be repaid) and therefore will have higher rates.

The prime rate is the interest rate charged by established lending institutions to private firms with histories of financial viability, credit-worthiness and ample collateral. If we relax any of these conditions, then the interest rates will increase. General Motors, for example, might secure a \$20 million loan from Chase Manhattan with \$50 million in collateral at a 10 percent interest rate. Whereas, a nursing home operator with negative net equity (i.e., he owes more than he owns), a history of defaulting on his loans, and no collateral might secure a \$25,000 loan from a loan shark at a 50 percent interest rate. In each example, the interest rate reflects the "prevailing rate" in the market. For that reason, states must be more specific in limiting interest rates than by merely using some ambiguous standards of "prevailing rates." Usually these limits have been tied to prime rates--as in the case of Colorado--or the Medicare rate of return (1.5 times the interest rate on short term certificates in the Hospital Insurance Trust Fund). These are exogenous limits or limits that are beyond the control and manipulation of the owner. The state may wish to impose still further limits because under normal market conditions, as interest rates increase, the demand for money decreases. This is not the case when interest expenses are guaranteed. Thus, during a highly inflationary period, the state may wish to curtail building by limiting reimbursement for interest rates to, for example, rates below the prime rate.

As the size of the loan increases, interest expenses also increase. The state would not want to approve loans in excess of the value of the home because then the state would be providing an operator with an interest free loan unrelated to the care of Medicaid patients. Approved mortgages, therefore, should be equal to or less than the value of the home. The state has two options. It can either directly limit the amount borrowed or it can attempt to encourage owner equity by limiting loans to a percent of the home's total value. In 1974, for example, New York did not recognize interest expenses on an amount in excess of 75 percent of the value of the home. The state can also impute a borrowed amount to the home. Again in 1974, Minnesota imputed to each home an equity base of 35 percent of the value of the home and outstanding debt of 65 percent. Interest expenses were only reimbursed on 65 percent of the home's value regardless of actual expenses.

e. The Home as a Leverage Device

A related issue is how the owners use their homes as collateral over time. If the home is appreciating, then an owner may use his home to borrow well in excess of the book value of the facility (which is based on the undepreciated historic costs of the building and the historic cost of the land). When debts exceed assets (receivables, stocks, the facility, etc.) an owner is said to have "negative net equity." The states have been concerned over this situation for a number of reasons. If the state uses historic costs to value facilities, and if the state pays for interest, then a home whose refinancing places it in a negative net equity situation forces the state to reimburse the home for a loan which the

state as a lender would not have issued. Further, the state would be paying for a loan without controlling how that loan was used (e.g., it could be used to improve the nursing home or put the owner's children through college). Even if the state did not reimburse interest for loans in excess of the facility's book value, it would want to control excessive borrowing. The state may fear that an owner who has over extended himself will divert funds intended for direct patient care to pay off the loan. Further, if an owner cannot meet the payments on his loan, the home may go into bankruptcy and create problems for Medicaid patients not only in terms of finding new homes for them, but also in terms of the patient trauma that often accompanies involuntary moves.

In addition, the state may feel that because it has contributed heavily to retiring an owner's mortgage (although technically all the state has done has been to purchase the use of the services of the capital), it should have control over the use of any loans which were issued with the facility as collateral. When owners borrowed in excess of the home's value, state officials often felt that the homes were being drained of all their value for the private enrichment of the owners and that controls had to be placed on the use of such loans. Finally, negative net equity can become a political issue. A state Medicaid director may have a very difficult time explaining to legislators, citizens groups and reporters why the state should permit a negative net equity at all.

All of these factors explain why the state may be concerned over negative net equity. That concern, however, may be misplaced.⁸ The financial standard for issuing a loan after all, is not the historic cost of an item but its market value. Given the rapid rise in real estate in general, limiting loans

to the historic costs of a home imposes an artificially low ceiling on a facility; this in turn, would prevent an owner from raising capital which might be essential for the business and might make nursing homes an unattractive investment. Second, the amount of interest payments per se is not the issue, rather it is the ratio of interest payments to all other reimbursable costs. This does not mean that an operator cannot over extend himself. It does mean, however, that negative net equity does not guarantee that that will occur. Finally, there is an equity issue which has broad implications for the bedstock; namely: why should an old home have to have low interest payments compared with a new home, particularly if the value of the services of their capital stock are the same? The most pragmatic response is because it costs the state less. However, this may also force older but perfectly acceptable homes out of the industry or produce an incentive for unnecessary renovation.

Be that as it may, if the state wishes, it has a number of ways of controlling or discouraging negative equity situation. Two have been mentioned. It can either not recognize interest expenses in excess of a given percentage of the home's book value, or it can impute a percentage borrowed and only pay interest expenses on that imputed amount. Massachusetts has come up with a rather inventive solution which goes beyond disallowing interest expenses for excessive loans. Massachusetts will multiply the factor it uses to pay an owner a return on his equity by the amount borrowed in excess of the home's book value and subtract that amount from the state's payments.

f. Funding

The final issue concerning the cost of purchasing property is whether the state should permit an owner to have discretionary control over depreciation payments in excess of amortization. For purposes of clarification, we shall restate the discussion on mortgage payments: when state Medicaid programs reimburse property on the basis of costs, they usually recognize depreciation and interest expenses. Depreciation is typically calculated on a straight line basis. The homes, however, do not pay off or amortize the principal of a loan on a straight line basis. During the first few years of a mortgage, the payments are mostly interest expenses. Amortization is very low and as a rule much lower than the amount depreciated by the state for reimbursement purposes or by the home for tax purposes. Again, only depreciation is recognized as a tax deductible business expense. Amortization is not deductible. Thus, during the early years of a mortgage, the home receives a double bonus: a tax shelter and bonus of payments in excess of actual property costs. When owners took this money out of the nursing home and used it for other purposes, some claimed this was a misuse of state money. The question is, should the state pay that "bonus"?

If the answer is no, then the state has several options. First, it can pay amortization costs only. If an owner, however, takes out a five year mortgage for a facility with a 40 year useful life, the state has replaced the "problem" of the depreciation bonus with a problem of rapid and costly purchase of the home by the state for the owner. The state can adjust amortization payments to reflect the useful life of a facility, but if this is all that is done, then other problems will follow. Assume, for example, that the state limited amortization to a maximum of 2.5 percent

of the value of the building with a 40 year useful life. The state in effect would pay amortization that was less than or equal to 2.5 percent but, not more. As a result, an owner would be unable to amortize his building within 40 years.*

The state has an alternative to directly limit payment to debt service. It can require that whenever depreciation exceeds amortization the difference be funded or set aside in a special account. This fund could be restricted to paying the difference between amortization and depreciation when amortization exceeded depreciation. The fund might also be used for renovation. The advantage of funding is that it assures that reimbursement for property is spent on the property and not pocketed by the owner. It also lowers the risk to lending institutions because it creates a contingency fund for mortgage payments. Finally, if the state does the funding itself, it can save a considerable amount of money--particularly, as in the case of New York in 1977, when the funding account is a ledger of obligations and not actual cash put aside.

The disadvantage of funding is that it imposes limits on the owner's use of what he considers his own money, and interferes with his judgment as to how the money might best be used and thus might make nursing homes a less desirable investment.

* If we assumed, for example, that an owner had acquired a 25 year mortgage at 9 percent for full value of his property he would amortize 1.12 percent of the cost of the building the first year, 1.22 percent the second, 1.33 percent the third. By the tenth year he would have amortized 2.74 percent and .24 percent of the building's cost would not be reimbursed. If an owner refinanced every ten years with a 25 year mortgage at 9 percent he would only pay off 69 percent of the building's mortgage at the end of a 40 year period.

g. Return on Investment

The rate of return is the product of selecting an appropriate rate (that is, one which reflects the risk of investing in a nursing home relative to the risks of all other investments), and the investment base (e.g., the owner's personal investment, the book value of the homes, the assessed value of the home). Federal law, however, permits only one type of explicit return, that is, a return on the owner's personal investment. The amount of money an owner is willing to invest will be a function of how much he can borrow, how interest on capital loans are paid, how high the state's rate of return on the owner's investment is and the nature of all other investment opportunities and rates of return available to the owner. It should be stressed that the state is not required to pay a rate of return. The decision to pay a return and the level of return selected will depend upon the state's assessment of how many Medicaid beds it needs, how many are available, how lucrative the total Medicaid rate is, whether holes in the methodology permit owners to reap "hidden profits", and how and if incentives within the methodology should replace returns on investment.

3. Should property costs for similar homes be treated differently because of different ownership arrangements (e.g. leased or owned property) or ownership histories (i.e., the sales and leasing history of a facility)?

One of the most political aspects of the reimbursement system was recognition of sales and leases by the states and subsequent abuses that allegedly took place, namely, trafficking or the rapid sale and resale of a home in order to maximize Medicaid reimbursements and sales/leaseback arrangements or a situation where an owner would set up a dummy corporation to buy his own home and then would lease the home back to himself at inflated rates. The issue is, should the state take ownership arrangements or sales

histories into account when it reimburses a home? For example, should identical homes with identical historic costs be reimbursed differently because one is owned while the other is leased, or because one has had only one owner while the other has been sold half a dozen times, or should the state pay the same amount regardless of real estate transactions and ownership arrangements?

a. Recognizing Sales

The advantage of recognizing sales is that it allows the industry to freely change and adjust to new circumstances. Also, the ability to sell a facility and realize profit is a common attribute of real estate markets. Failure to recognize sales may make nursing homes an unattractive investment and create a shortage of beds. The primary disadvantage is that given Medicaid's role and the peculiarities of "market prices" in the nursing home industry, recognizing all sales would place no limits on the price of a home. The incentive to the owners would be to restrict their patients to Medicaid recipients (because private pay patients would be sensitive to nursing home rates and unable to support ever escalating real estate prices) and to traffic in nursing home. Further, even if the sale's prices recognized for reimbursement were capped (for example, at replacement costs of a facility) there would be a strong incentive to sell and re-sell the home so that capital reimbursement could be kept at the maximum.

If the state wishes to recognize sales but wishes to maintain some control over the size and nature of the transactions it has three basic options. The state can place limits on allowable sales prices, provide financial incentives for owners to hold onto their property, and/or require state licensure, and/or certificate of need approval prior to any sales transaction.

The methods for redetermining the value of a home and setting limits are similar to those encountered in setting the value of the facility initially with one exemption: reevaluation is dynamic. It implies changing conditions. In order to establish price ceilings, the state can use three standard real estate appraisal methods: depreciated replacement approach, income approach, and market value approach.

A description and the relative merits of each of these methods have been discussed above. Additional procedures are necessary, however, in the instance of the depreciated replacement method. This requires that the cost of rebuilding the facility be calculated and multiplied by the ratio of the number of useful years remaining in the building over the total life of the building. Thus, if the replacement cost of a 10 year old home with a 40 year life is \$500,000 then the depreciated replacement cost equals $\$500,000 \times \frac{30}{40}$ or \$375,000.

If the limits on sales prices are higher than the unadjusted value of the unsold home and if sale is the only way an owner can realize an appreciation in the value of his property, then there is an incentive for owners to sell in order maximize capital revenues. (This does not mean that they leave the business. Owners can merely sell each other their homes.) States have attempted to counter this with incentives for owners to hold onto their property (or disincentives to sell). While this does not do away with the issue, it may lessen the number of sales and therefore lessen the impact that sales would have. One approach is to increase rewards or decrease penalties with years of ownership. Minnesota has used both. It had a recapture provision to recoup depreciation payment when the sales price exceeded the book value of the home (i.e., the undepreciated historic cost of the home). However, the amount recaptured was reduced one percent for each month that the owner held

onto his property. In addition, the owner's return on his equity increased for each year for the first 25 years an owner held onto his property. The effectiveness of these devices, of course, rests with how they affected the price of the home and the profits that an owner could reap by selling his facility relative to the return he received by holding onto his facility.

Perhaps a more direct way to control sales is to require state approval prior to any transaction in order to review the financial implications, the need for the home under new ownership, and the character of the new buyer. New York has used this approach with a modicum of success for several years.

The most effective method for controlling the impact of sales on the reimbursements, however, is simply not to recognize them. The state can set the value of a facility once and then ignore any sales transactions which might occur over the useful life of the home. This is a static approach which may seriously undervalue the property over time and encourage physical deterioration and a decline in the bed stock. The state may also impute a cost, a fee that it is willing to pay for the services of the capital. The advantage of this approach is that it bypasses all of the detailed intricate calculations required when costs are determined according to the actual costs incurred by the home. The disadvantages lie in the problems with deriving and justifying the rate, gauging the effect the rate will have on the availability of Medicaid beds and on the industry in general and showing that it is consistent with federal "cost related" regulations.

b. Ownership Versus Leasing

After the state has determined whether and how it will recognize sales, it must decide whether it will distinguish between identical homes which are owned and those which are leased. The advantage of recognizing leases is that it makes nursing homes attractive to investors interested solely in building and owning but not operating a home, it allows operators with the administrative talent but lack of capital to operate homes, and it allows an owner to extend the legal protection to his property beyond that which incorporation of the firm permits. If both the operating and capital portion of the home are incorporated as one firm, business failure would mean that the owner would lose his facility. If the facility is incorporated under a separate entity, then an owner would retain ownership of the home even if the operating side of the business went bankrupt.⁹ Thus, if an owner wishes to avail himself to the protection of incorporation, he must set up two firms: a corporation which owns the facility and one which leases the building and operates the home. This is often referred to as a sale/leaseback arrangement.

(Rents from sale/leasebacks, however, are rarely accepted for reimbursement. The state's usually treat the operator as an owner and pay him accordingly.)

The disadvantage of leasing is that the leasee does not build up equity in the capital he is paying off nor does he profit from the appreciation in the value of the facility upon its sale. Finally, the leasee may have less flexibility than an owner. The leasee is required to meet fixed payments over time to the holder of the lease. If interest rates drop or if mortgage terms become more advantageous, it will not likely affect the lease holders willingness to renegotiate the lease in the middle of its term. An owner, on the other hand, can attempt to change his mortgage payments any time by renegotiating a new mortgage or refinancing his home with any

bank that is willing to make him an offer. From the state's perspective, the prime disadvantage of a lease is that with few exception leases will be more expensive than the state's payments to owner operated facilities. As John Holahan has observed,¹⁰ under perfectly competitive conditions the lease will always be more costly than an owner operated facility because the leaseholder must be reimbursed for all of the same costs as an owner plus receive a fee managing the lease. If conditions are less than competitive, for example, if certificate of need restrictions on entry and the sale of facilities keep the number of beds and facilities below that which is demanded, lessor's will be capable of extracting monopoly rents. In order for the state to assess whether this is undesirable or not, it must be able to gauge 1) how much more expensive leases are than owner operated property, 2) whether the increased leasing costs might be compensated for by lower operating costs (as might be the case with large chain operated firms), and 3) how much the bed stock is increased by paying a premium for leases. Certainly, if the products provided by leased and owner facilities are the same and the bed supply is sufficient, there is no reason to recognize higher leasing costs. Under this or any other situation where the state feels there is little advantage to recognizing leases it can either set a ceiling on leases equal to what the facility would have received had it been owned. If the information necessary to make that calculation is not available, then the state can impute what the reimbursement should be from payments made to comparable facilities. Of course, the most effective way to prevent leasing problems from arising is not to recognize any differences between owned or leased facilities.

Intertwined among the ownership and sales issues are the federal and state tax incentives which make a strong distinction among owning and leasing and selling or holding onto property. The state must recognize the impact that those laws have on the industry if for no other reason than it may be tax laws rather than the reimbursement methodology that provoke much of the behavior in the market. Reimbursement changes alone may be an insufficient policy device for encouraging owners, for example, to hold onto their property until it has exhausted its useful life.

4. How can the reimbursement of operating costs encourage efficiency?

Generally, we have very little problem with identifying the most efficient firms in industries where output and quality are clearly defined. The most efficient firm is simply the firm capable of producing a given quality and number of goods at the lowest price. In nursing homes, however, neither the quality nor the final output are clearly defined. This places the state in an unsettling situation particularly in regard to operating costs. (While capital cost reimbursement has problems, there is little difficulty assessing the quality of final output of the construction or renovation of the home). If the state pays too much, it may be paying for inefficiency, higher quality of care than it requires or a higher level of profits than it feels appropriate. If the state pays too little, it may force a reduction in the quality of the care, a decrease in the amount of care, or a reduction in the bed supply.

States have defined acceptable levels of efficiency in three ways. They have placed limits on specific cost items (most notably administrative salaries, management fees and nursing hours) set ceiling on cost centers (for example, nursing care or dietary services) or capped total

costs. These limits were either set arbitrarily, established according to exogenous standards or indices (for example, Minnesota used the wholesale price index for raw food to limit increases in raw food prices, Connecticut used a Connecticut specific index reported by the Bureau of Economic Analysis of the U.S. Department of Commerce to limit wage increases for hourly paid employees, and several other states employed the CPI or GNP deflator to control for overall increases in rates) or fixed by the cost experience of the industry as a whole or of groups of homes within the industry (e.g., costs were limited to average costs or some percentage of the average costs. Frequently, variation around the mean was addressed by using standard deviation to set limits.) Caps were applied across all homes or among groups of homes. The most frequent categories used to disaggregate homes were care level (SNFs or ICFs), geographic regions, facility size and sponsorship (public, voluntary and non-profit).

Exogenous standards for limiting costs are by definition beyond the manipulation of the industry or an individual home. They therefore increase the state's ability to control costs while at the same time presenting a justification of those limitations based on general trends in the economy or a particular factor market that the industry is dependent upon. It is often politically impossible to establish all limits based on exogenous constraints. The industry's experience is therefore frequently used as a standard against which individual firms are compared.

When the industry becomes the only standard for efficiency, however, problems can set in. First, after an industry has been reimbursed on the basis of costs for an extended period of time, there is nothing which prevents every firm from being inefficient.¹¹ Thus to use the industry's average experience as a measure of efficiency may be meaningless. Further,

it may be incorrect to assume that a home with an average per diem of 1.20 percent of the mean is less efficient than one that is 1.05 percent of the mean particularly since the methods of comparing homes are relatively crude. Thus the more expensive home may have more heavy care patients, a greater array and intensity of services, more elaborate equipment, or a greater amount of space per patient. The more expensive facility could also have inept administrative practices, be overstaffed or have excessive profits.

Second, when the industry experience is broken down by certain groups of homes the groupings themselves may serve to perpetuate inefficiencies. For example, let us assume that nursing homes with 100-150 beds are able to employ all their resources more efficiently than smaller or larger homes. If we then categorize homes by bed size (49 beds or less, 50-99, 100-149, 150 or more) we have effectively insulated all the other homes from the impact of the most efficient group, that is, the cost pressure for homes to seek out an efficient size is eliminated.

5. How can reimbursement be linked to the quality of care provided by the home?

Defining the quality of care in nursing homes may be the most perplexing issue in the long term care area. There does not seem to be any clear consensus as to what quality care is or how it can be measured. What makes this all the more difficult is that in general, policymakers feel that homes should be reimbursed according to the quality of care they deliver. This situation is complicated by the fact that beyond very minimal requirements there does not appear to be a direct relationship between cost and quality, that is, ever increasing amounts of money do not guarantee any improvement in the quality of care a patient receives. In order to overcome this difficulty the state ideally must define quality as some composite of inputs, process and outcomes which is readily linked to

the patient's condition, not easily influenced by the subjective judgment of the quality surveyor or pressure from the owner, inexpensively translated into an administrative task, and amenable to quantification and to cost analysis. Short of the ideal, the state can select from among one or more of the following three techniques.

First, it can fine the homes for providing poor care. In order for the fine to be effective it must be larger than the cost of rectifying the deficiency but not so large that enforcement officials would refrain from issuing the fine or that homes would refuse to accept patients who might cause the home to be penalized. California, for example, had a \$1,000 fine for bedsores. As a result hospitalized patients with bedsores reportedly had difficulty being placed. While this approach is not necessarily linked to the reimbursement system, it can be. In Michigan, for example, a home's reimbursement was reduced according to deficiencies discovered in the facility.

Second, the state can devise a grading system for the homes and reimburse accordingly. New York, for example, in 1976 paid homes according to 5 quality standards: Very Good, Good State, Good Federal, Needs Improvement, and Unacceptable. Very Good homes did not have a ceiling on their costs. The four remaining categories were paid according to a declining percentile among the Good State homes, Good Federal at the 35th percentile, Need Improvement at the 25th percentile and Unacceptable at the 10th percentile.

This approach requires two conditions be met in order to be successful. First, the grading system must consist of measurements which are relevant to quality care, can be objectively applied across homes, and provide defensible quality categories.

The other condition is that the cost of efficiently providing care should be established and used to set state prices for different quality levels. Failure to meet the first condition has broader implications than the short run likelihood that some homes providing good care may be penalized and some bad homes rewarded. It will mean that over time the state will restructure the industry's delivery of care around ineffective standards. Even if ineffective, wholesale change is often costly. Failure to accurately link costs to quality may either prevent homes from meeting certain quality standards or have them produce too much of one kind of care. For example, Connecticut used to use a point system based on inputs: the more points a home had, the higher its rate. The points, however, were so poorly related to cost, that a legislative audit found that at an additional cost of \$1.00 per day, an ICF could become an SNF, and receive an additional \$10 per day. The industry's response was predictable. By the time the point system was abandoned in 1975, 87 percent of the total beds were SNF beds.

Third, states can link payment to patient disability. Illinois has devised a methodology which reimburses nursing costs according to patient point counts. Point counts in turn are established according to various patient conditions and the needs associated with those conditions (e.g., a patient receives no points if he can move about independently, two points if he can move about with some staff assistance, and three points if he is totally immobile and must be moved by staff). This approach has several advantages. It recognizes differences in patient disability, thereby attempting to offset the incentives under cost-related systems that are capped to cream-skim the healthiest patients. And, it focuses on nursing care, the largest cost center most likely to affect the quality of care.

In a critique prepared by Thomas Walsh and Mike Koetting (of the Illinois Department of Public Health), they argued that a patient assessment tool such as the point system had four problems:¹²

- 1) It was administratively complex and costly.
- 2) Discretion on the part of the caseworkers produced discrepancy in patient classification.
- 3) Simple patient assessment techniques such as the point system "cannot capture all of the needs which can be expected to affect the cost of operation." (However, as the instrument becomes more refined and complex it becomes more difficult to administer uniformly).
- 4) There were questions as to how consistent the relationship of points were to each other in the assignment of levels of disability and the costs associated with those disabilities. For example, if homes were reimbursed more than it cost to feed a bedridden patient and less than it cost to perform a daily colostomy irrigation then there would be an incentive to feed patients in bed and either not admit patients with a colostomy or not perform the irrigation properly or as frequently as would be desirable.

Despite these problems, Illinois felt that the point system was more desirable than other patient assessment techniques and much more desirable than not assessing patients at all.

II. The Industry, The Reimbursement System, and The State

Because the political analysis begins with the 1974 scandals, we shall set the stage by describing the industry and the Medicaid reimbursement system at that time.

A. The Nursing Home Industry

In 1974, there were 715 nursing home facilities in New York State with 81,675 beds. Three quarters of the beds (61,910) were in Skilled Nursing Facilities (SNFs) (see Tables 1 and 2). The remainder were in Health Related Facilities (HRFs), New York's counterpart to what were known in other states and in federal regulation as Intermediate Care Facilities (ICFs). More than half of the homes and 65 percent of the state's beds were in the New York City Metropolitan region. The average facility in the state had 114 beds, although SNFs tended to be larger than HRFs and facilities in the New York City Metropolitan region were on average larger than upstate homes. Proprietary facilities accounted for 54 percent of the state's beds, voluntary facilities for 25 percent, public facilities for 12 percent, and the hospital based facilities for 9 percent. There was a greater percentage of proprietary beds in the New York City Metropolitan area than there was upstate and a greater percentage of public and hospital based beds among upstate facilities than in the New York City Metropolitan area. That pattern repeated for HRFs with the exception that voluntary beds were more prevalent in the New York City area.

Total average operating per diem expenses (exclusive of capital costs) for SNFs and HRFs were \$37.54 and \$24.40 respectively. Among both types of facilities, hospital based beds were the most expensive. After that the

Table 1

Skilled Nursing Facilities in New York State, 1974
Number of Homes and Beds, by Type and Size of Facility and Hospital Service Region

Type of facility and bed size	Southern New York										Rest of State																			
	State total					Northern Metropolitan					Northeastern New York					Central New York					Rochester (Region)					Western New York				
	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	Total No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds		
Skilled nursing homes																														
All bed sizes	461	55,890	250	36,708	129	23,019	50	6,563	71	7,126	211	19,182	50	4,824	62	5,536	44	4,015	55	4,807										
Under 50 beds	101	3,341	39	1,215	13	411	7	235	19	569	62	2,126	11	297	19	650	15	603	17	576										
50 - 99	137	10,488	55	4,079	23	1,679	11	830	21	1,570	82	6,409	26	2,049	25	1,941	14	1,047	17	1,372										
100 - 199	143	19,107	89	12,108	40	5,632	25	3,325	24	3,151	54	6,999	8	1,128	14	1,810	12	1,583	20	2,478										
200 - 299	55	12,375	47	10,592	37	8,449	6	1,284	4	859	8	1,783	3	610	3	745	2	428	0	0										
300 and over	25	10,579	20	8,714	16	6,848	1	889	3	977	5	1,865	2	740	1	390	1	354	1	361										
Proprietary																														
All bed sizes	314	36,515	186	26,160	89	16,163	45	5,138	52	4,859	128	10,355	25	1,996	39	3,336	30	2,328	34	2,695										
Under 50 beds	67	2,270	24	776	2	75	6	196	16	505	43	1,494	9	246	11	381	13	517	10	350										
50 - 99	89	6,840	38	2,816	17	1,228	10	765	11	823	51	4,024	10	792	18	1,416	9	667	14	1,149										
100 - 199	106	14,064	77	10,368	30	4,198	24	3,139	23	3,031	29	3,696	4	548	8	1,036	7	916	10	1,196										
200 - 299	43	9,417	38	8,276	32	7,038	5	1,038	1	200	5	1,141	2	410	2	503	1	228	0	0										
300 and over	9	3,924	2	3,724	3	3,524	0	0	1	300	0	0	0	0	0	0	0	0	0	0										
Voluntary																														
All bed sizes	109	12,638	57	8,315	40	6,856	3	350	14	1,109	52	4,323	13	1,075	16	1,141	8	1,032	15	1,075										
Under 50 beds	34	1,071	15	439	11	336	1	39	3	64	19	632	2	51	8	269	2	86	7	226										
50 - 99	35	2,664	16	1,201	6	451	1	65	9	685	19	1,463	10	824	4	286	2	130	3	223										
100 - 199	22	2,986	11	1,554	10	1,434	0	0	1	120	11	1,432	0	0	3	344	3	462	5	626										
200 - 299	9	2,339	7	1,897	5	1,411	1	246	1	240	2	442	1	200	1	242	0	0	0	0										
300 and over	9	3,578	8	3,224	8	3,224	0	0	0	0	1	354	0	0	0	0	1	354	0	0										
Public																														
All bed sizes	38	6,737	7	2,233	0	0	2	1,075	5	1,158	31	4,504	12	1,753	7	1,059	6	655	6	1,037										
Under 50 beds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0										
50 - 99	13	984	1	62	0	0	0	0	1	62	12	922	6	433	3	239	3	250	0	0										
100 - 199	15	2,057	1	186	0	0	1	186	0	0	14	1,871	4	580	3	430	2	205	5	656										
200 - 299	3	619	2	419	0	0	0	0	2	419	1	200	0	0	0	0	1	200	0	0										
300 and over	7	3,077	3	1,566	0	0	1	889	2	677	4	1,511	2	740	1	390	0	0	1	381										
Hospital based facilities																														
All bed sizes	70	6,020	15	2,502	10	2,008	3	374	2	200	55	3,438	15	810	15	1,079	15	1,003	10	546										
Under 50 beds	33	1,090	1	43	1	43	0	0	0	0	32	1,047	7	213	8	242	11	394	6	198										
50 - 99	21	1,483	6	404	3	220	2	134	1	50	15	1,079	7	477	3	239	2	135	3	228										
100 - 199	8	996	2	290	1	140	0	0	1	150	6	706	1	120	3	346	1	120	1	120										
200 - 299	5	1,157	4	905	3	665	1	240	0	0	1	252	0	0	1	252	0	0	0	0										
300 and over	3	1,294	2	940	2	940	0	0	0	0	1	354	0	0	0	0	1	354	0	0										

Source: New York Department of Health, Unpublished data.

Table 2

Health Related Facilities in New York State, 1974
Number of Homes and Beds, by Type and Size of Facility and Hospital Service Region

Type of facility and bed size	Southern New York										Rest of State																							
	State total					Northern Metropolitan					Northeastern New York					Central New York					Rochester (Region)					Western New York								
	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	Total	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds	No. of homes	No. of beds			
Health related facilities																																		
Proprietary																																		
All bed sizes	176	10,695	92	12,175	49	7,468	18	2,273	25	2,434	84	6,520	23	1,767	27	1,944	17	1,485	17	1,485	17	1,485	17	1,485	17	1,485	17	1,485	17	1,485	17	1,485	17	1,485
under 50 beds	47	1,728	13	443	5	1,177	2	68	6	198	34	1,285	11	415	12	435	6	245	5	245	5	245	5	245	5	245	5	245	5	245	5	245	5	245
50 - 99	58	4,139	27	1,909	13	935	7	486	7	488	31	2,230	8	621	8	578	6	437	9	437	9	437	9	437	9	437	9	437	9	437	9	437	9	437
100 - 199	43	5,684	30	4,102	13	1,673	5	681	12	1,748	13	1,582	2	296	6	717	3	326	2	326	2	326	2	326	2	326	2	326	2	326	2	326	2	326
200 - 299	24	5,568	18	4,145	15	3,471	3	674	0	0	6	1,423	2	435	1	214	2	477	1	477	1	477	1	477	1	477	1	477	1	477	1	477	1	477
300 and over	4	1,576	4	1,576	3	1,212	1	364	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Voluntary																																		
All bed sizes	81	8,121	51	5,961	37	4,533	3	463	11	965	30	2,160	4	213	11	692	8	812	7	812	7	812	7	812	7	812	7	812	7	812	7	812	7	812
Under 50 beds	19	690	9	298	5	177	1	28	3	93	10	392	2	72	5	183	1	46	2	46	2	46	2	46	2	46	2	46	2	46	2	46	2	46
50 - 99	31	2,211	17	1,220	13	935	1	71	3	214	14	991	2	141	4	298	4	303	4	303	4	303	4	303	4	303	4	303	4	303	4	303	4	303
100 - 199	22	2,681	17	2,141	12	1,483	0	0	5	658	5	540	0	0	2	211	2	226	1	226	1	226	1	226	1	226	1	226	1	226	1	226	1	226
200 - 299	7	1,693	6	1,456	6	1,456	0	0	0	0	1	237	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
300 and over	2	846	2	846	1	482	1	364	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Public																																		
All bed sizes	29	3,021	5	645	1	235	0	0	4	410	24	2,376	12	1,195	3	512	5	259	4	259	4	259	4	259	4	259	4	259	4	259	4	259	4	259
Under 50 beds	11	387	1	25	0	0	0	0	1	25	10	362	4	144	0	0	4	159	2	159	2	159	2	159	2	159	2	159	2	159	2	159	2	159
50 - 99	6	426	1	52	0	0	0	0	1	52	5	374	4	320	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
100 - 199	7	1,027	2	333	0	0	0	0	2	333	5	694	2	296	2	298	1	100	0	100	0	100	0	100	0	100	0	100	0	100	0	100	0	100
200 - 299	5	1,181	1	235	1	235	0	0	0	0	4	946	2	435	1	214	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
300 and over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Non-hospital based facilities																																		

Source: New York Department of Health, Unpublished data.

rankings differed. For SNFs, voluntary facilities (\$45.22) were followed by public (\$39.85) and the proprietary firms (\$34.50). For HRFs, however, that order was reversed. Proprietary homes were the most expensive (\$27.15) and voluntary facilities the least (\$22.33).¹³

A more detailed picture of the 1974 operating costs was constructed by a special legislative committee--the Moreland Act Commission.¹⁴ The Commission examined the 1974 cost reports from a sample of 145 skilled nursing facilities. Per diem costs for 15 different cost centers were regressed on 29 independent variables such as occupancy rate, wage rates, size of the facilities, ownership, and patient characteristics. Stepwise multiple regression was used to select those variables which best explained variation in each cost category.

The study found that the average total operating cost was \$35.60, but the range of costs was \$21.16 to \$72.85. (see Table 3). Costs were higher in urban areas and increased with the size of the facility. Voluntary homes were one and a half times as expensive as proprietary homes with costs for government facilities occupying the middle position.

The higher costs associated with increases in size were not adequately explained, nor were the high costs of voluntary homes.¹⁵ It had been thought a major difference between voluntaries and proprietaries was that non-profits included physicians' fees, therapists charges and pharmaceuticals in their costs while proprietary firms billed separately for those services.¹⁶ On average, these ancillary services accounted for only \$2.12 of the \$15.36 per diem difference between proprietary and voluntaries.¹⁷ Evidently, higher costs for voluntaries were due primarily to a tendency for non-profits to be larger and located in higher wage areas than other types of homes.¹⁸

The study also indicated that there was a very weak correlation between patient characteristics (age, sex, ambulatory/non-ambulatory and length of

Table 3

1974 Per Bed Costs for Skilled Nursing Facilities:
Total Operating Cost and Costs for Selected Cost Centering*

BY REGION	Total Operating	Nursing	Dietary	Administrative	House Keeping	Repair & Maint.	Laundry & Linen
Albany	\$ 30.85	\$12.82	\$4.48	\$2.85	\$1.51	\$2.15	\$1.20
Buffalo	28.66	10.52	4.78	2.76	1.79	2.38	0.83
Rochester	26.99	10.05	5.13	2.48	1.48	2.12	0.87
Syracuse	26.87	11.03	4.54	2.51	1.40	1.73	0.93
White Plains	39.19	14.44	5.81	3.85	2.15	3.19	1.14
New York	39.04	15.56	6.01	3.23	2.80	2.85	1.05
BY NO. OF BEDS							
0-50	24.38	9.67	4.58	3.20	1.38	1.91	0.65
51-100	29.10	11.96	4.68	3.14	1.72	2.11	0.88
101-200	33.81	13.64	5.23	3.20	2.03	2.45	1.04
201-300	32.99	13.24	5.60	2.90	2.29	2.13	0.95
over 300	42.15	15.77	6.20	3.27	2.76	3.40	1.19
BY OWNERSHIP							
Voluntary	44.93	16.02	7.21	3.90	2.79	3.92	1.14
Proprietary	29.57	12.78	4.69	2.83	2.07	1.80	0.89
Government	39.32	14.12	5.47	2.99	2.03	3.34	1.34
Avg.	35.60	13.93	5.54	3.16	2.27	2.66	1.04
**Range	21.16-72.85	5.87-23.34	2.79-11.85	1.48-9.47	0.22-5.18	0.73-5.80	0.36-2.19
*Sample - 145 facilities							
**Sample - 52 facilities							

Source: New York State Moreland Act Commission on Nursing Homes and Residential Facilities, Reimbursing Operating Costs: Dollars Without Sense, Albany, New York, Moreland Act Commission, March 1976, pp. 42, 44, 47, 48, 49, 51, 52.

stay) and total costs. For example, although on average one third of the patients in an SNF were non-ambulatory, the range within the sample was as high as one half of the patients and as low as one sixth. Yet the ambulatory status appeared to have no effect on costs.¹⁹

Similarly, the regression analysis indicated that nursing costs did not seem to be affected by patient characteristics.²⁰ Nursing costs were the largest single expenditure within a New York nursing home. They averaged nearly 40 percent of total operating costs. It had been assumed that as patients became more ill, they would require more nursing care and therefore nursing costs would increase. Two factors tended to work against this assumption. First, the state required that each home have at least 2.5 nursing hours per patient regardless of medical status. This increased costs unnecessarily in homes with relatively healthy patients or in homes where total required nursing hours produced a fractional employee (e.g., 9.2 nurses). The latter would force the home to hire a full time employee to cover the .2 nurse. Second, many large voluntary homes "which have expensive and well staffed nursing services [were] often less likely to admit relatively sick patients than other homes."²¹ This would suggest that a number of facilities may have employed a large number of nurses inefficiently or for reasons other than patient care.

B. Medicaid Reimbursement

Medicaid, of course, was the major purchaser of care. Medicaid patients represented 24.3 million patient days or 78.0 percent of the total patient days of care provided by the industry.²² Medicaid patients also represented 76.9 percent of the industry's revenues although New York City Metropolitan area homes relied more heavily on Medicaid than those upstate.²³

Not only did Medicaid have a major impact on the nursing home industry, but nursing home expenditures represented the largest Medicaid expense. Medicaid spent more than \$867 million of its total \$2.55 billion Medicaid budget on nursing home care.²⁴

In 1974, Medicaid payed out these \$867 million through an elaborate cost based reimbursement system. A cost related methodology was first used by the Medicaid program in 1967. Between 1967 and 1974, the industry and the state played a complicated game of cat and mouse.²⁵ The industry would find loopholes and the state would make incremental adjustments. By 1974, nursing home reimbursement had become exceedingly complex. Conceptually and administratively it had been divided into two sets of payment regulations: one for capital costs, the other for operating costs.

1. Capital Cost Reimbursement²⁶

In 1974, the state used three different methods for reimbursing depreciation/interest/return on equity, capital arms length rental, and imputed rental. A home could choose between the depreciation/interest/return on equity or arm's length approach. If either method was inapplicable or reimbursements very low, then the state reimbursed on an imputed value basis which served as a minimum or payment floor for nursing homes.

a. The Depreciation/Interest/ Return on Equity approach permitted a home to depreciate two and a half percent of the book value of its fixed assets each year. Specifically, it allowed straight line depreciation on an assigned 40 year life for the facility (although if owners employed the component method of depreciation--depreciating individual parts of the building--they could reduce the "effective life" of the building and fixed equipment to 35 years). The book value of the home equalled either the facility's construction

cost depreciated over time or, in the case of an arm's length sale, the replacement cost of the undepreciated value of the building and the fixed equipment. (For example, the original cost of a 20 year old property would be inflated by the Dodge Construction Index and half of the value of the asset would be subtracted as the depreciated portion of an asset with a 40 year life,) If the Department viewed a sale as taking place between related parties, the sale would not be recognized and reimbursement would be unaffected. Interest charges were reimbursed if they "reasonably reflect[ed] prevailing market conditions at the time the loans were concluded." Prevailing market conditions, however, are ambiguous because interest rates and expenses are a function of the prevailing interest rates, the nature of the lender, the credit worthiness of the borrower, and the security for the loan.²⁷ The interest rates will be higher if the prevailing rates are high, if the lender is a private financier or corporation specializing in risk capital rather than an established commercial bank or savings and loan association, if the credit of the borrower is known to be bad, and/or if no security is put up for the loan. Thus, "prevailing market conditions" might and did result in interest rates that were well above the prime rate.²⁸ In addition, interest on loans in excess of 75 percent of the book value of the property were not recognized. Finally, proprietary homes received a return on their equity equal to the Medicare rate of return (which was equal to 1.5 times the Hospital Insurance Trust Fund).²⁹ Equity was defined as the book value minus the debt on outstanding principal.

b. Arm's Length Rental was designed for leases between unrelated parties.* Arm's length agreements for New York City nursing homes arranged prior to the Medicaid program served as the base. This figure was inflated each year by the Dodge Construction Index. Adjustments were also made for the cost of money in the mortgage markets. The adjusted figure served as the maximum for the New York City area. The maximum for the remainder of the state was 80 percent of the New York City ceiling. In some instances, the Department would refuse to pay maximum because it felt that the owner would benefit too greatly, although this effort to constrain payments was limited by the Department's meager auditing capacity. Under no conditions, however, was an open sale-leaseback arrangement recognized as a valid property transaction which affected reimbursement levels (i.e., an owner sells his property then leases it back from the buyer).

c. Imputed Rental equaled 80 percent of the maximum permitted under the Arm's Length Rental approach. If the home was a building converted from some other use, the imputed rental equaled 56 percent of the Arm's Length maximum. Imputed rental was employed under two conditions. First, a home could have experienced a cashflow problem because its amortization was well in excess of depreciation and refinancing was not available. This was not impossible. During the early 1970's there was some reluctance on the part of lending institutions to become involved in the nursing home industry because there was a feeling that demand was insufficient to support all the beds that had been or were being constructed. Second, a home might not have an arm's length agreement

* Unrelated parties are individuals who are financially unrelated, e.g., they are not partners in other business ventures. According to the Medicare Provider Reimbursement Manual, a provider is unrelated if he is not "to a significant extent...associated or affiliated with or has control of or is controlled by" the other individual.³⁰

and/or costs information on the home's construction was not available or unreliable. In those cases, a home received an imputed rental payment.

Generally, newer homes selected the depreciation approach and older homes would take advantage of one of the rental arrangements. In 1975, for example, 45 percent or 139 of New York's 305 proprietary homes were being reimbursed on the depreciation/interest/return on equity method, 35 percent or 109 homes received arm's length rental payments (36 of which received less than their leases stipulated) and 93 received imputed rentals.³¹ Of the 61 new homes built between 1971 and 1973, over 60 percent were paid on the basis of the depreciation approach in 1975 while a third of the new homes were paid according to the arm's length rental approach.³²

2. Operating Cost Reimbursement³³

Operating costs were based upon yearly cost reports each home submitted. Individual rates were set by first performing a desk audit, adjusting costs for occupancy (i.e., if actual occupancy was less than 90 percent, then a 90 percent occupancy rate was imputed) and then grouping homes by size, location, and sponsorship. For each group, a weighted average per diem was calculated and four separate screens were applied. First, individual home's costs in excess of a 110 percent of each group's combined average per diem expenditures for administration, dietary and house-keeping were disallowed. Second, if a home's overall costs (exclusive of property costs, rates of return and certain ancillary services) were greater than 115 percent of the overall costs of the group, the excess costs were disallowed. Third, the allowable per diem for a health-related facility could not exceed 60 percent of the average per diem skilled nursing facility in the same

size, location, and sponsorship category. Fourth, homes with "significant operating deficiencies" would not be paid in excess of their actual costs or their group's average.

In addition to general screens, there were limits on the salaries of owners and relatives of owners, on total administrative salaries, on expenses to related organizations, on automobiles and other moveable equipment. When limits were not otherwise specified, the Department relied upon Medicare's reimbursement regulations and limitations.

The payment method had two efficiency incentives. First, a home without "significant operating deficiencies" received a percentage of the difference between its actual costs and the group's average. Second, the rate for any given year was based upon cost reports submitted two years prior to the effective date. Those costs were inflated by a "roll factor" (a composite index of a variety of cost trends). If a home's costs were less than the projected rate, then the home was permitted to keep the difference.

Finally, the system had a fairly liberal exceptions process. Large unexpected increases (as in fuel or electricity) and new services and increases due to union contracts were passed through, that is, they were not subjected to screens or limitations.

3. Problems with the 1974 System

The methods for capital reimbursement had several deficiencies. First, there was no cap on building costs. As long as actual costs were less than Arm's Length or Imputed Rental, a builder had an incentive to control his expenses so that he could receive the difference between his costs and rate under one of the rental systems. However, once the cost of the building exceeded the revenues received under the rental system, the builder had no incentive to contain costs. Despite the fact that building costs were uncapped, costs were not totally unreasonable. A sample of 27 proprietary

SNFs and HRFs built in the New York City Metropolitan area between 1972 and 1976, showed that the average bed cost \$16,762.³⁴ This was well above the 1975 national average for a bed with a comparable number of square feet (\$12,017).³⁵ The national costs, however, did not reflect the high cost of land in the New York City area.

Second, the decision as to whether to own or rent could have large revenue implications. If we assume, for example, that the 1974 \$2,000 per bed arm's length rental limit for the New York City area was used as a mortgage payment and if an owner was able to get a 25 year mortgage at 9.41 percent (the national mortgage rate for commercial property in 1974) then the arm's length agreement limit could support a \$19,000 mortgage on each bed.³⁶ If the owner used the depreciation interest/return on equity approach, however, he might be able to receive payments well in excess of \$2,000 per bed. The justification for wide differences in rates between owners or renters of the same property was not very strong. Third, determining whether rental agreements were arm's length or not was not only administratively arduous, but senseless given that both the lessor and lessee knew what the maximum payments were prior to negotiation. Since owners had no reason not to ask the maximum and renters were indifferent as long as the cost could be passed onto the state, negotiations could start and end at Medicaid's ceiling.

In addition, the capital reimbursement system supported some very expensive facilities, particularly among "28-A" homes or private non-profit homes built with state money through a special state program. For example, proprietary homes spent approximately ten percent of the revenues on capital costs. Among the voluntaries, capital costs accounted for 15 to 25 percent

of their total costs. The cost per bed in the "28-A" homes was \$31,761, nearly twice that of the profit homes.³⁷ By 1975, the 28-A program had funded 89 projects with 17,571 beds.³⁸ The Moreland Act Commission noted that 28-A projects under construction in 1975 had an average of 483 square feet per bed while a sample of proprietary homes under construction during the same period had 360 square feet per bed. Not only were the 28-A homes larger, but they cost up to \$12 per square feet more than proprietary homes.³⁹ The desirability of these homes was not at issue but rather whether Medicaid should support facilities as expensive as these were.

Reimbursement for operating costs had two problem areas: the characteristics used to group homes and the exceptions process. Disaggregation by size and sponsor may have encouraged excessive payments. Noting that there was no research "supporting a causal relationship between size and quality," William Pollak has argued against using size as a nursing home reimbursement variable because it not only "eliminates incentives to build and operate at a scale that minimizes costs" but it also "perpetuate[s] all scales of operation--inefficient as well as efficient--since homes that operate at inefficient scales will be reimbursed at rates reflecting the higher costs historically associated with their scale."⁴⁰ This is particularly pertinent to New York because the size of the facility had such a dramatic affect on the cost of services (see Table 3) and yet there did not seem to be any relationship between patient needs, patient mix and the size of the facility.⁴¹ If patient needs and quality are unrelated to size, then reimbursement based on size becomes a questionable and expensive proposition.*

* Under some circumstances, the state may wish to support homes which were built on an inefficient scale. In some rural areas, for example, where a 50-bed facility would remain half empty, the state might want to maintain a very small but inefficient home.

A similar argument can be made regarding distinctions based on whether a facility is proprietary or voluntary. Qualitative differences are implied in this distinction. Voluntary homes are presumed to render better quality care than proprietary homes because they do not need to generate profits and can plow all of their resources into patient care. There were three problems with this distinction. First, our understanding of voluntary institutions is sufficiently imprecise that we cannot make that qualitative assumption.⁴² Second, the literature is mixed on whether there are any qualitative differences between voluntary and proprietary homes.⁴³ Third, if the state wishes to reward quality of care it should attempt define quality and reimburse accordingly.

The exceptions process opened up the reimbursement system, let homes incur costs in excess of the screens and still receive full reimbursement. The pass-throughs on union contracts, in particular, were very expensive. This is not surprising because if the state would pay for the settlement, the operators had little reason to engage in hard negotiations with their staff.

Finally, a weakness of the entire reimbursement system was the way it was administered by the Department of Health. The Department was not staffed to do an adequate job. Prior to 1971, New York had not performed any field audits.⁴⁴ In 1974, the state had 14 auditors to review the books and cost reports of New York's 715 nursing homes.⁴⁵ There were no penalties if costs were overstated.⁴⁶ This effectively allowed the home to take out a "free loan" from the state by overstating costs and the paying back only the principal. And accounting and cost allocation systems were not uniform.⁴⁷ These inadequacies created a very loose environment in which operators had considerable leeway in reporting their costs.

III. The Politics of Reimbursement: 1974-1977

A. 1974: Scandals and Allegations

In early September, 1974, New York state auditors reported that an audit of 58 nursing homes for the two year period of 1969 through 1970 revealed over \$4.6 million in unwarranted Medicaid claims. Yachts, family cars, jewelry, and college tuition for some nursing home owners' children were among the more unusual items billed to Medicaid. The audit had cost \$168,000 and had netted almost 25 times that amount in recoveries.⁴⁸ Assuming that the audited homes were representative of the proprietary sector, one state representative argued that Medicaid could recover \$24 million if it had expanded its audit effort.⁴⁹

The New York Times followed this revelation with an extended series on the state's nursing home industry. This series became a detailed investigation into the operations of two prominent nursing home operators, Eugene Hollander and Bernard Bergman. Anecdotal information about the poor care delivered in homes owned and run by both these men and their financial manipulations received almost daily coverage for over a year.

Eugene Hollander was a well-known philanthropist and honorary president of the Metropolitan New York Nursing Home Association.⁵⁰ He came to the New York Times' attention when it was alleged that he was responsible for \$611,000 of the \$4.6 million of the 1969-1970 overcharges.⁵¹ That interest increased when it was reported that he had attempted to sell four nursing homes for \$29 million to the newly created Touro College.⁵² While this was not unusual, per se, other facts made it provocative. Hollander was, for example, also chairman of Touro College, the college allegedly was going to lease the home back to Hollander at an inflated rental rate (this was intended to improve the college's finances), and the sale's contract

Hollander had with the college would have been reportedly cancelled if the Department of Health failed to approve the new lease.⁵³ What made this newsworthy, however, was that the college's board of trustees included some of New York State's most prominent political figures.⁵⁴ But the story's newsworthiness must not be confused with improprieties. The Department of Health did not recognize sales/lease back arrangements and therefore did not pay for them. Hollander's relationship with Touro College was discovered by the state, the requested increase in rents was denied and the Hollander/Touro College sale cancelled. The state was less diligent in its monitoring of Hollander's books. Special audits revealed that the \$600,000 of questionable bills initially uncovered was only a small portion of Hollander's total Medicaid fraud. All told, Hollander's false Medicaid billing allegedly net him \$10.5 million.⁵⁵

Compared to Bernard Bergman, Eugene Hollander was a simple country operator. Although the figure put on Bergman's Medicaid theft amounted to only \$2.5 million, fraud was not the factor which propelled Bergman into the limelight. Rather, it was intrigue: political, financial, and criminal. Bergman had used a number of political contacts to overcome state agencies' resistance to either approve rate increases, grant certificates of need or issue licenses to a number of his homes. Several state legislators and their staff applied pressure on program administrators. In turn, Bergman either purchased proprietary services from his political friends (for example, insurance coverage or legal services) or made donations to their campaigns.⁵⁶ In either case, Medicaid was billed for the expenses incurred.

Fascination with Bergman also revolved around his reported long term care empire of 100 nursing homes, his extensive holdings in other states, his dummy corporations, hidden partners, complex real estate arrangements, and his alleged ties to organized crime. All of this was reported in enormous detail by the New York Times and other New York papers.

The daily reports on Hollander and Bergman were augmented with anecdotal allegations of poor care, fraud and legal but questionable manipulations of Medicaid's reimbursement by operators. Between September and December, the Temporary State Committee on Living Costs and the Economy, a legislative committee created in 1972 to look into the economic problems of the elderly, focused all of its energy on nursing homes. Andrew Stein, chairman of the committee, was an outspoken critic. He directed the committee to investigate and issue reports on various aspects of the nursing home industry. The political disquiet stirred up by the exposé in September had grown to a roar by December with the media, legislators, religious groups and private citizens demanding public investigations and reforms.

B. 1975: Investigations, Increased Regulations and Revised Capital Reimbursement

It is not difficult to draw lessons after information has been collected, sorted and analyzed, and after time has lent some perspective. In 1975, however, when Governor Carey took office, he had neither sufficient information nor the luxury to sit back and wait. He was under heavy pressure to respond to the scandal. In January, Governor Carey convened a Moreland Act Commission to investigate the nursing home industry. Morris Abrams was appointed chairman. The Commission held months of hearings, performed a number of studies, attempted to synthesize the material already collected, recommended legislation and issued seven reports which have become basic policy references. The

Governor also appointed Charles J. Hynes as Deputy Attorney General for the Office of Special Prosecutor and allocated sufficient funds so that lawyers, auditors and investigators could be assigned to investigate the industry. The Temporary State Commission on Living Costs and the Economy continued to issue reports and call for change. Indeed, 1975 was a year for investigation and recommendations. At one point, there were seventeen different government agencies from the federal, state and local levels investigating the industry.⁵⁷ Several themes were repeated throughout these investigations. First, there was continual testimony that patient care was frequently poor and abusive. Second, reports found widespread fraud. As a result, omnibus legislation designed primarily to protect patients, root out undesirable operators, and severely punish fraud was passed.

One immediate result of the investigations and the exposé was an increased level of state monitoring and regulation. Between January 1975 and December 1976, the state reviewed 121 capital cost statements and disallowed \$51 million for Medicaid reimbursement (76 new construction proposals were withdrawn for failure to provide necessary information or proceed on schedule). Eighty facilities were fined \$326,000 for operating or establishment violations. Five homes had their establishment certificates revoked. One hundred and twenty four nursing homes administrator licenses were reviewed. Two licenses were revoked, six surrendered, five forfeited and two censured. Ten homes were placed in receivership. Eighty-five homes were closed.⁵⁸ Between January 1975 and September 1976, 8,694 beds were closed (6,630 were SNFs and 2,064 were HRFs (see Table 4)). Over 70 percent of beds closed were proprietary. During the same time period, however, 11,330 beds opened, more than half were HRFs and more than half were proprietary.

Table 4

CHANGES IN SUPPLY OF LONG TERM CARE BEDS, 1975-1976

Source: Department of Health, Bureau of Facility Planning

If closings were a good proxy for regulatory actions, then 1975 was a year of high activity. As Table 4 shows, in 1975 New York closed 6,015 beds, nearly four times the average number of annual closings for the preceeding five years.⁵⁹ On an annualized basis, there were approximately 3,500 beds closed in 1976. In 1976, then, there were fewer unsatisfactory beds and/or monitoring was not as intense.

The scandals also contributed to the adoption of a new capital reimbursement methodology in March, 1975. The new system itself had been in the works since 1972 and was formally presented to the Department of Health in October, 1974 by the Public Health Council's Ad Hoc Committee on Capital Cost Medicaid Reimbursement Rates.⁶⁰ The Committee proposed that capital reimbursement should embody five principles:

- (1) The state should pay for a facility only once.
- (2) Reimbursement must be reasonably related to delivery of health care services and not dependent upon real estate transactions and changes in ownership.
- (3) Excessive profits must be eliminated, particularly when they are totally unrelated to improvement of either the quality or quantity of health care services delivered.
- (4) Similar facilities should receive similar reimbursement without regard to the nature of ownership or subsequent transfers.
- (5) Delivery of health care is not best served by inducing, through the potential of economic gain, frequent transfers of health care facilities.⁶¹

The payment method developed (and adopted in March, 1975) from these principles required that all new facilities be reimbursed on the basis of historic costs without any changes made thereafter. Reimbursement was the same regardless of whether a home was owned or leased. Depreciation/interest/return on equity approach was the only method used to calculate Medicaid rates. Buildings and fixed equipment constituted the base for depreciation. The building was depreciated over a 40 year

life, using a straight line depreciation method. Each year, 2.5 percent of the original cost of the land was reimbursed. Depreciation in excess of amortization was funded. If the building was renovated, the renovation was basically treated as a new building or addition with its own useable life and with a separation depreciation account. Interest expenses for loans in excess of the unamortized portion of the building were not reimbursed.

The Public Health Council took a different stance with existing facilities. It recommended that reimbursement for capital be frozen at current rates (i.e., future sales transfers or new leases would not increase rates). The Council argued that this was reasonable because of "the difficulties in ascertaining original cost of many existing facilities (which in some instances may well be impossible), the inequities in applying new rules retroactively...[and] the legal problems and general unfairness which would result." 62

By not recognizing transfers, this method did away with incentives for sales-leasebacks, trafficking, stock swaps and a number of other financial transactions designed to increase Medicaid real estate reimbursements. It did away with the problematic distinctions of arm's length and non-arm's length agreements. It refused to recognize distinctions based on ownership or sponsorship of any kind. This payment method also put a tight and permanent lid on the cost of capital. But, it was an incremental solution. It did not overhaul the entire approach to reimbursement but accepted past commitments and approvals by the state; although it did phase out the imputed rental option. Change would come but costs would become more reasonable because of a gradual turnover in the nursing home stock and because inflation would bring the fixed capital costs for the remaining homes into line over time. Further, by using

historic costs for new facilities and freezing rates for existing facilities, this system would, over time, encourage deterioration in the physical stock and some decline in the number of beds. (This incentive was mitigated to some extent by the treatment of renovations as a "new" facility.) The payment mechanism also encouraged ownership over leasing since one aspect of leasing--the rapid periodic increases in rents--was disallowed unless it was directly related to renovation or expansion. Finally, by phasing out imputed rental, the reimbursement floor was eliminated which further diminished the desirability of nursing homes as investments.

While this method of reimbursement was perceived by the Department of Health as a satisfactory solution to the capital reimbursement problem, it was not acceptable to the Temporary State Commission on the Cost of Living and the Economy. In April, 1975, the Commission issued its final report on nursing homes recommending, among other things, that "real property costs be treated as one set of cost, regardless of ownership, based on actual value of the facility, and regardless of all financial arrangements, loans and rental agreements;" that reimbursement be linked to standards of quality of care, that reimbursement caps be tightened and justification and documentation of all costs be more stringent.⁶³ The report called for a moratorium on rates for one year until a new system could be devised.⁶⁴

The influence of the Temporary State Commission outlasted its life. As the months went by, the Moreland Act Commission continued some of the work of its predecessor, but did not produce the details of a new reimbursement system until 1976. There was apparently a feeling within the legislature and the executive that the payment system had to be entirely overhauled. Despite the March, 1975 reimbursement changes which altered the payment methods for new homes, there was some resistance to paying any nursing home (old or new) under rates determined by a reimbursement system which had produced so much scandal and was so lucrative. The "generosity" of the system was particularly important given that there were early indications that 1976 state expenditures would exceed state revenues.

Thus in October 1975, an "interim rate" was announced a few days prior to when the State was technically charged with announcing each facility's 1976 rates. The interim rates were an effective freeze of 1975 payments. The justification for the freeze presented a few months later was that the Department of Health felt that "new legislation concerning 1976 reimbursement, and still unresolved aspects of Part 86 of the Commissioner's rules have made it impossible to promulgate final health facility rates at this time."⁶⁵ The freeze remained in effect through October, 1976. It produced, among other things, extensive litigation by individual nursing homes and by the associations.

The rate freeze also prompted many homes to cancel employee wage increases and payment for unused sick days. In December, Local 144 of the Hotel, Hospital and Nursing Home Union objected to this violation of its 1975 contract and threatened to strike.⁶⁶ The union represented 12,000 workers working in 90 New York City metropolitan homes with approximately 16,000 patients. The strike was averted by a court order, an advance payment of October Medicaid bills, and arbitration.⁶⁷

C. 1976: Fiscal Crisis, Rate Freeze, Fair Rental Value, Quality Ratings, and Boycott

1976 was a year of confrontation, confusion and adjustment. It was a year of reports and responses to reports. Mostly, it was a year of fiscal distress when the state and the industry had to learn to live with less.

In January, Governor Carey had to confront a \$900 million deficit in the state budget. The Governor sought to close the gap between projected expenditures and revenues by cutting back on the expenditures. In his state of the state address, the Governor announced that his proposed budget would "finance little that is new and discontinue much that is old."⁶⁸ The \$3 billion dollar Medicaid program was subjected to a variety of cost containment measures. A number of reductions in nursing home rates were considered. One solution advocated by the Department of Health would have produced a 10 percent across the board cut in long term care rates.⁶⁹ There was strong legislative resistance to this approach, a feeling that arbitrary cutbacks might harm good homes, force a general decline in quality and bring on another scandal. The Governor countered with a recommendation that rates be frozen and standards reduced.⁷⁰ Finally, in March, a compromise Medicaid budget bill was passed whereby reimbursement would be linked to one of five quality ratings; the higher the quality, the higher the reimbursement ceiling.^{71*} The quality ratings had been developed by the state in 1975 to inform consumers about quality of care in the home. By tying quality to payment, the state was able to contain costs (by adjusting the payment rates for each quality rating) while satisfying the charge that quality care was not only recognized but rewarded. Legislation and implementation are, of course, two very different things. The state did not work out the details and arrive at new rates until October, 1976.

* A home was reimbursed the lessor of its costs and the ceiling.

Those details included the adoption of different methods of reimbursing capital and operating costs. For capital, the Moreland Act Commission report, Reimbursement of Nursing Home Property Costs: Pruning the Money Tree, presented an alternative approach for reimbursing capital called "fair rental value." In terms of operating cost, the Moreland Act Commission report had less influence. The payment method for operating costs finally adopted was more directly affected by legislative negotiation than legislative reports. The reimbursement issues will be discussed below.

The new rates issued in October did not bring the financial relief the industry was seeking. In fact, more than half of the state's homes were paid at a lower rate than under the 1975 freeze.⁷² Further, the state made the new rates retroactive to January, 1976, forcing some homes to pay the state back as much as \$250,000.^{73*} The industry was upset and angered. The New York Metropolitan Nursing Homes responded in November with a Medicaid boycott. Under the threat of state anti-trust proceedings, however, the boycott was broken.⁷⁴

In the next section, we shall examine these events more closely. We shall review two Moreland Act Commission reports, the responses to those reports and the effect that the reports finally had on policy.

1. The Moreland Act Commission Reports

Between January and April, the Moreland Act Commission issued a series of seven reports that were greeted by many as state-of-the-art

* The actual recoupment, however, did not begin until 1979. The state took back these funds by reducing payments to the home. Payments were never reduced more than six percent of a home's rate. If this was insufficient, a home was given up to three years to pay back the excess payments.

references on state policy and the nursing home industry. For the purposes of this paper, two studies are of particular interest: Reimbursement of Nursing Home Property Costs: Pruning the Money Tree and Reimbursing Operating Costs: Dollars Without Sense. The reports have become known by their subtitles and we shall refer to them as Money Tree and Dollars Without Sense. Because the reports were official statements by the Moreland Act Commission, we shall also refer to the reports as the Commission's statements or recommendations.

a. Capital Costs: The Fair Rental Value

Money Tree was issued in 1976. The report is basically divided into two parts. The first examined and analyzed two capital reimbursement systems--the one in existence in 1974, and the one adopted in March 1975.* Through simulation modeling, the Commission attempted to show that even under what they considered to be modest assumptions, the 1974 system provided nursing home operators with handsome returns to their investments and encouraged trafficking. Trafficking was supposedly rampant. The New York Times reported that in 1973 alone, there were 200 applications to transfer property among the proprietary homes.⁷⁵ While there may have been a strong incentive to traffick, the requirement that the state approve transfers before a home could be sold kept the actual number of sales very small. In a review of sales between 1971 and 1974, the Moreland Act Commission discovered 31 transfers of ownership (and in two instances reimbursement declined as a result of the sale).⁷⁶ In other words, approximately three percent of New York's proprietary nursing homes changed hands each year for the three year period examined. "Trafficking" clearly had not reached epidemic proportions.

* See Tables 8, 9, and 10 for a summary of the major differences between these systems.

After examining and dismissing the 1974 system as an acceptable approach, Money Tree discussed and dismissed the 1975 reimbursement system because the Commission felt it

- (1) "May result in socially uneconomic conversion of nursing home real property to other uses."
- (2) Forced the state to pay more than is necessary.
- (3) Required homes to fund depreciation even though this meets "no pressing public policy objectives" and needlessly interferes with proprietary operator's ability to manage his home.
- (4) Applied only to new homes.⁷⁷

After rejecting the state's approaches, Money Tree set forth its set of objectives for its solution--Fair Rental Value (FRV). The Commission's payment objectives for proprietary facilities were as follows:

- (1) Reimbursement should be based on the costs of efficiently providing debt and equity financing for nursing homes real property. Included in such costs for proprietary homes should be a fair rate of return for contributed equity capital.
- (2) Reimbursement should not change for reasons that have nothing to do with the value of a facility to the public as a nursing home. Thus, reimbursement should not in the future vary solely as a result of sales, whether these be concluded at arms length or otherwise; on the basis of whether a facility is leased or owned; or, as a result of changes in an owner's financing arrangements.
- (3) Reimbursement should take account of broad inflationary trends which increase the value of an investment in nursing home property so that in the typical case reimbursement at least would be sufficient to maintain code-compliant and otherwise acceptable nursing home property in use as a nursing home. It would be unwise public policy to court the risk that, as a result of low reimbursement, nursing home property would be converted increasingly to other uses. (It might be equally unwise, however, to reimburse at rates high enough to prevent such conversions in cases where increases in the land value of a particular facility are extraordinarily high, as might be the case if the nursing home land would otherwise be used for a shopping center or office building.)

- (4) Reimbursement should be sufficient to meet the property costs of those nursing home facilities to be built in the future but only if these are efficiently designed, efficiently constructed, efficiently located as well as efficiently financed.
- (5) The reimbursement system, should be simple to administer and based upon explicit rules and regulations.⁷⁸

From these objectives, the Commission designed a system which would pay a proprietary home one rate regardless of what financial transactions it engaged in. The building and fixed equipment for new homes would be reimbursed on the basis of cost or for existing facilities either the book value recognized by the Department of Health* or lacking that (as in the case of imputed rentals) an estimated "reasonable value" based on the property value of comparable facilities. This cost base would be allotted a 40 year useful life. In lieu of actual interest rates, FRV would assign a "rate of return" on the assets equal to the Medicare rate of return. From a functional standpoint, however, FRV basically imputed what the costs of the building and mortgage should have been and then used those figures to construct a level payment amortization schedule based on the cost of the building, a 40 year life and interest rates equal to the Medicare rate of return. Unlike, a traditional mortgage, however, the interest rate (i.e., the Medicare rate of return) would be recalculated every ten years (based on the average of the preceding five years in order to "accommodate long-term changes in competitive returns on investment and... also provide a measure of stability required for an owner to plan his financial arrangements efficiently.")⁷⁹

Land costs would be used to provide an additional rate of return to the owner. The costs of the land would be adjusted each year by an index

* This implied accepting the Department's distinction between arm's length and non-arm's length.

similar to GNP deflator.* This would recognize inflationary trends. This adjusted figure would be multiplied by one-third the Medicare rate of return.

Voluntary homes were treated differently. The 1975 system was retained because it "appear[ed] to the Commission to be fundamentally sound (and with a few changes)...should be retained."⁸⁰ These changes included limiting reimbursement to the depreciation and interest method, a recapture provision** if the facility were sold for some use other than nursing care--and designation of the undepreciated replacement cost method to set the cost of the facility if a proprietary home was sold to a voluntary sponsor. Voluntary sponsors leasing their facilities would be paid according to FRV. It should be noted that Money Tree strongly supported funding of depreciation for voluntaries in part because of state precedent and in part because it was a "matter of acceptable fiduciary practice" that the trustees of a voluntary institution should follow.⁸¹

The publication of Money Tree produced an immediate response from the Public Health Council and the industry. Morton Hyman, Chairman of the Public Health Council and the individual most responsible for formulation of the reimbursement system adopted in 1975, responded in a lengthy rebuttal. Hyman argued that "every major problem and concern raised by the Morland Commission Report....was recognized by the Public

* The land value would be based on the original cost of the land when it was first used to support a nursing home. If the land had been used for nursing home care for 20 years or more its value was inflated forward. There was no explanation for why this distinction was made or why 20 years was a critical point.

** A recapture provision allows the state to recoup payments it made to the home for depreciation purposes. Usually, recapture applies when a home is sold at a price in excess of its book value.

Health Council" and that adoption of FRV might not only lead to "serious abuses and disadvantages" of the 1979 system but add a few of its own including windfall profits for some nursing home operators and severe financial problems for others.⁸² Specifically, Hyman noted that FRV's return on land was a costly departure from the principles of using historic costs as the basis for reimbursement.⁸³ The FRV return on land could (using the Money Tree's assumptions) pay an owner back five times the original value of his land over a 50 year period.⁸⁴ Hyman found the Commission's recommendation for one reimbursement system for proprietary and another for voluntary homes to be inconsistent with the Money Tree's reimbursement objectives and the potential source of a number of problems.⁸⁵ The use of previous arm's length transactions to set the base value for proprietary homes was also identified as inconsistent particularly because the Commission had argued that it was often impossible to distinguish an arm's length sale from a non-arm's length sale.⁸⁶ Hyman further illustrated situations in which homes could either make very lucrative returns or be unable to meet their debt service.

The New York State Health Facilities Association, the principal voice for the proprietary sector, responded to the FRV proposal through an A.D. Little commissioned report. A.D. Little disputed the assumptions Money Tree had made about the operation and profitability of the nursing homes. A.D. Little further charged that FRV produced a mortgage coverage ratio^{*} that was so low (estimated at 1.02 to 1.13) that banks would not issue mortgages for future nursing homes.⁸⁷ The eight banks surveyed required between 1.4 to 1.2 minimum mortgage coverage ratio before they would issue a mortgage. The report claimed that the assumption of a 40

* The mortgage coverage ratio is the ratio of operating funds available to cover debt service to the mortgage obligation.

year life on the building ignored the reality of changing standards, technology and residential location patterns.⁸⁸ The alleged insufficiency of the rate, it was argued, would lead to defaults on a substantial number of the estimated \$500 million in nursing home loans. This would force banks to reserve a significant portion of those loans "thus reducing the credit available to other forms of commercial enterprise and to the home loan market, ...(although) for the most part this reduction has yet to take place."⁸⁹ A.D. Little also suggested that FRV would have a series of undesirable effects on localities because it would lower the assessed value of the homes and therefore the property taxes that could be assessed. FRV would make it difficult for homes to meet their cost and therefore communities should expect an increasing difficulty in collecting the taxes that are due. The report also states that tax collections would decline as a form of protest:

Property owners must be expected to take some independent action if they are restricted to returns which they believe are inadequate. This is what has been done by owners of rent-controlled properties in several localities, most visibly in New York City. Reaction by property owners to the perceived inequities of rent control has taken the form of delays and postponements of property tax payments with a resulting increase in arrears. Property tax arrears in New York City more than doubled in 1974, from \$101 million to \$223 million. On June 30, 1974, 21.8 percent of the City's apartment house parcels had fallen in arrears, as compared with 11.5 percent of all real estate parcels.

While some of the arrears may eventually be collected, a significant portion will not be collected. In the meantime, the effect upon the cash flow of cities such as New York has been devastating.⁹⁰

Upon the threat of delays in tax collection, A.D. Little placed the threat of abandonment.

Deficient reimbursement rates will not only cause payment delays and collection problems for localities, in some cases it is logical to expect outright abandonments given existing operating requirements and penalty provisions and profit allowances which are likely to be insufficient to even cover inflationary effects. We do not wish to raise the specter of massive abandonments because we do not anticipate massive abandonments at this time. However, we do believe that the threat of abandonment is very real in poor, high-crime rate, urban communities where the clientele is predominantly or exclusively Medicaid patients. Nursing homes located in these areas do not have the private-pay patients, and the charges and revenues collected from private-pay patients tend to serve as a buffer against abrupt changes in Medicaid reimbursement policies. It is in the poorest communities where the clear likelihood of abandonments cannot be ignored and it is these communities that can least afford the loss of revenues. In the case of abandonments, these communities would be ill-equipped, not only from a financial standpoint but also from an operating standpoint, to take over the responsibility for operating the homes. Certainly the patients must be cared for and very probably the State would be forced to accept the financial responsibility. In the meantime, as financial and operating arrangements are made, it would be necessary to transfer those in need of regular medical attention to acute hospitals while hospital beds are tied up by patients who would normally be discharged to nursing homes. The overall Medicaid program costs to the State and localities would increase dramatically since the per diem rates in acute hospitals are roughly three times the rates in proprietary nursing homes.⁹¹

At this point in time, however, the industry's clout and persuasiveness with the legislature was minimal, so A.D. Little's arguments carried little weight. Hyman and the Public Health Council, however, were essential to the implementation of the new plan. Given the problems that Hyman had with FRV, he was able to force the Moreland Commission to agree on a compromise FRV plan which, among other things, eliminated the provisions for a special treatment for a proprietary home sold to a voluntary sponsor (that is, undepreciated historical costs were used rather than undepreciated replacement costs) and for use of a land based inflationary factor. In terms of the application of FRV to existing and new facilities, the Commission made only partial concessions, by accepting the rents required by leases drawn

prior to March, 1975 if those leases were also bona fide, valid, and non-cancellable and the terms were reasonable. Hyman had argued for exempting pre-existing mortgages as well, claiming that leases and mortgages were merely "alternative means of financing" and that the state could not alter the existing contracts between a nursing home and its landlord or its mortgage holder.⁹² This became particularly troublesome if an owner had to refinance his home in order to adjust FRV and was unable to find a bank willing to deal with him. Given that the scandals had made banks reluctant to loan money to the homes, this was not improbable.⁹³ Hyman predicted that FRV applied across the board could lead to defaults on mortgages and foreclosures by the banks. The Commission was unconvinced. Pre-existing mortgages were not recognized and were subjected to FRV calculations. In recalling the negotiations with the Moreland Act Commission, Hyman noted:

The most compelling argument, I suppose, that Morris Abrams made at the time, and which led to our agreeing to the fair rental proposal in its modified form was that we should try it and see what happens. He said, "you can't tell me that it isn't going to work," and Morris (Abrams) was very forceful on this point, "you are also not offering any alternative." Our proposal was that the Commissioner should be empowered with a degree of discretion to review existing reimbursement, taking into account numerous factors which would enable him to reduce capital cost reimbursement if, based upon these various factors and examination, we felt it was in the public interest and appropriate to do so. Morris (Abrams) felt that that was inviting litigation; that the standards were too broad, and again he said, "I am offering a specific proposal and we ought to give it a try."⁹⁴

Thus the compromise FRV was worked out and a recommendation for adoption from the Public Health Council to the Department of Health was issued in March 1976. FRV was formally adopted shortly thereafter.

b. Operating Costs: The Efficient Care Standard

The Moreland Act Commission's affect on operating cost reimbursement was less dramatic. This may have been due to the fact that the Commission was less critical of the methodology employed in New York in 1975 than it was of the capital cost methodology. Further, the Commission's alternative to the existing system was less developed, more theoretical and more complicated than most of its other solutions.

Specifically, the Commission recommended in its March, 1976 publication of Dollars Without Sense, the adoption of a payment mechanism based on "Efficient Care Standards." This was a combination of several techniques. First, expected costs for a home would be derived by using step-wise multiple regressions. Nursing home costs, broken down by cost centers, would be regressed on a number of independent variables (size, patient mix, location, etc.). Each home would have its rates set by classifying the home according to the relevant independent variables and then summing the regressions's appropriate estimated costs. Second, standards for acceptable care would be set by low cost homes providing acceptable care. These homes would be used as Efficient Care Standards (ECS), that is, their costs would become a standard for the industry and reimbursement would be set accordingly. If the ECS were lower than the rates suggested by the regression analysis, then ECS would have been used.

A basic problem with this solution was that it was not presented in its final form. It required further work, better data, and time. Time may have been the limiting factor. It would not have been unreasonable, for example, for the refinement and pretesting of ECS to extend into the next fiscal year. Further, other considerations forced the state to adopt a different tactic.

2. Legislative Compromises, Legal Battles, Union Troubles and Boycott

In March, 1976, the same month that the Moreland Act Commission came out with Dollars Without Sense, the legislature passed its fiscal 1976 Budget Bill on Medicaid. The nursing home component of that bill was the final item negotiated. The Department of Budget, acting on behalf of the Governor, has first asked that nursing home rates remain frozen at 1975 rates. It was estimated that this would result in an \$18 million savings.⁹⁵ When this was rejected by the legislature, the Department of Health recommended that homes be permitted to comply with federal standards of care which were lower than state standards. The Commissioner for the Department of Health estimated that a 200-bed home with a good-federal rating would cost the state \$173,000 less a year than one with a good-state rating.⁹⁶ In terms of quality, the Commissioner felt that many of the quality sacrifices (such as dropping the minimum college training required of a social worker from a Masters to the Bachelors level) would have a minimal impact on the actual care delivered.⁹⁷ In effect the Department was asking the legislature to void a portion of the 1975 reform legislation which mandated an increase in standards. It was felt by some legislators that this policy would have forced a decline in the quality of care and might have resulted in another scandal. The compromise which was finally passed into legislation eliminated the freeze, permitted homes to lower their quality of care but required that reimbursement be tied to a five level quality rating.⁹⁸ Low quality homes would have low rate ceilings. However, as the quality increased so would the rate ceiling. It was felt that this solution encouraged homes to increase the quality of their care.

Between the passage of this legislation in March and its implementation in October, the rates remained frozen at 1975 levels and the homes took their case to the courts. First the industry challenged the legality of the freeze. In September, the lower courts found in the industry's favor (although the state was able, upon appeal, to win a reversal in the higher courts in 1977).⁹⁹ Second, and perhaps more significant, the non-profits brought a suit against the state for failure to demonstrate that Medicaid rates permitted a home to survive at code compliant levels and meet the needs of the patients. The courts agreed with the complaint and suggested that the state either show a home how it could continue to operate at the state's rate or increase the rate. The request was initiated by the home. This gave rise to a multi-specialty state review team charged with performing "management assessments."

On another front, the nursing homes continued to have difficulty complying with their union contracts.¹⁰⁰ The homes insisted that they could not pay the union members their wage increases because Medicaid rates were frozen and the state's pass-through on union settlements had been eliminated. The unions countered that the contract had been agreed to prior to the rate freeze and that arbitration had found in favor of the union.* A special task force, headed by the former New York City Mayor Robert Wagner, was convened and reached an agreement in April which permitted the homes to increase their employees wages as well as unpaid salary increases of \$2 million. At the same time the agreement did not require an increase in state expenditures. This magic was basically an accounting and administrative solution which obligated the state to

* The unions had also unsuccessfully sued the state for failing to include the cost for their contract settlement in the Medicaid rate.

accelerate payments it owed the homes. It was magic, however, that could be worked only once and had a short-term remedial effect. The pressure from the unions would be constant force, which would prevent homes from easily adjusting to the state new reimbursement policies.¹⁰¹

In October, the state issued its new regulations and rates. Capital costs were reimbursed according to FRV. Operating cost reimbursement was redesigned to include quality ratings. Using its new reimbursement system, the state reduced the average SNF rates slightly to \$42.70 per day and HRF's average rates to \$27.40 per day.¹⁰² Retroactive to January 1976, these rates resulted in a \$2 million reduction in total 1976 state expenditures for nursing homes over 1975.¹⁰³

The new method for paying operating costs was particularly interesting. Operating costs continued to be grouped by care level and bed size. However, location and sponsorship were eliminated and cost centers and quality rating were replaced. Homes had their operating costs broken down by six cost centers: nursing, food and nutrition, leisure time activities, cleanliness and safety, social work and administration. Within each care level, size, and cost center group, homes were classified by five quality ratings: very-good, good-state (i.e., it met all state requirements), good-federal (i.e., it met the less demanding federal requirements), needs improvement and unacceptable. With the exception of cost centers classified as very good, quality ratings placed caps on reimbursement levels for each cost center. A good-state rating permitted a home to be reimbursed up to the 60th percentile of homes within that group, a good federal rating up to the 35th percentile of a comparable good-state group, needs improvement up to the 25th percentile of a comparable good-state group and unacceptable to the 10th percentile of a comparable good-state group. Unacceptable cost centers also had an additional 10 percent penalty reduction in the rate.¹⁰⁴

The elimination of the geographic and sponsorship categories in the new system can be viewed as a response to the 1976 fiscal squeeze and the state's muted dissatisfaction with the economic behavior of the voluntary homes. Location was not entirely eliminated as a prominent factor but, rather, was replaced with an adjustment for differences in regional salaries. In effect, the change favored homes in portions of the state where non-labor inputs were relatively inexpensive. The decision to mix the cost experience of voluntary, public and proprietary facilities reflected the sentiment that the distinction by sponsor was costly and unjustified. Throughout the Moreland Act Commission Reports it appeared as if voluntary facilities were invariably more expensive than proprietary homes. In some cases, like property costs, the differences were nearly two-fold.¹⁰⁵ While some could argue that the \$2.52 per diem difference in dietary services and the \$3.24 difference in nursing care were indications of high quality of care;* others could and did argue that the quality of care may have been too high or inefficiency may have been the driving force for higher costs.

Two additional changes in the New York State 1976 regulations merit comment. Homes which did not participate in Medicare received a 10 percent reduction in their Medicaid rate. Nursing homes in New York (and elsewhere in the country) often did not want to have any dealings with Medicare even though the certifications standards for Medicare and Medicaid SNFs were identical. In part, this can be traced back to the early 1970's when Medicare effectively extricated itself from the delivery of nursing home care by tightening up in its reimbursement system and issuing retroactive denials of payment.¹⁰⁶ While Medicare's coverage for nursing home care was and is limited, it does exist. When an elderly recipient

* See pages 30-32.

eligible for both Medicare and Medicaid failed to exhaust his Medicare benefits, the state was forced to pick up more of the tab than it would otherwise have to do. The only way a beneficiary would fail to "exhaust" his benefits would be if a home refused to participate in Medicare. As a result of tying Medicaid participation to Medicare participation, nursing home revenues from Medicare jumped from two to four percent of total revenues.¹⁰⁷ Finally, the "free loan provision" of the reimbursement system was eliminated. Homes which overstated their costs were charged seven percent on those excesses.¹⁰⁸

Given that voluntary homes had higher operating costs than other homes and that their capital costs reimbursements were not substantially altered by the new system, it was not surprising that the Hospital Association of New York State (representing approximately 100 voluntary facilities) issued a detailed critique emphasizing problems with the new method for determining operating costs. The Hospital Association objected to a number of the reimbursement components. Among them, it charged that the cost ceilings by quality rating and functional category were only accidentally related to what was actually happening in the home:

The arbitrary nature of both the rating system itself and the percentile limitations cannot be denied. The Department of Health, in its initial rate computations for 1976, used the 75th percentile to determine the cost ceilings for Residential Health Care Facilities rated "good-state". Subsequently, the ceiling was reduced to the 60th percentile after the Department discovered that total Medicaid expenditures using the 75th percentile would exceed what the State wanted to spend.¹⁰⁹

The Association felt that the new method had four major weaknesses.¹¹⁰

1) It penalized 40 percent of all "good-state" SNFs and 65 percent of good-federal SNF's regardless of how efficiently they were run.

2) Those penalized would be forced to cut back so that they would fall from "good state" to "good federal" or "good federal" to "needs improvement." The latter situation would force a home below minimum standard, make them liable for fines and penalties and yet deny them sufficient funds to improve their quality of care.

3) The lack of a uniform accounting system permitted homes to vary the way they recorded costs and did not allow homes to be grouped and compared by cost function without penalizing some homes. For example, two homes may have identical costs for nursing care and dietary services but one home lists meals for nurses under dietary while the other under nursing. That single discrepancy could push one of the homes over its ceiling for nursing while the other home would be fully reimbursed.

4) The quality ratings were inappropriate:

The rating system developed by the Department of Health was intended to inform consumers, using rather subjective criteria, of how the Department felt about the quality of services in any given Residential Health Care Facility. The rating system was not designed to be used in setting reimbursement levels. Since each State surveyor uses subjective (in addition to some objective) criteria when evaluating a Residential Health Care Facility service, a surveyor's opinion can cause a facility to incur large financial penalties, particularly since the difference between "Very-Good" (no cost ceiling imposed) and "Good-Federal" (ceiling at the 35th or 30th percentile) is ill defined. While an appeal mechanism does exist for facilities which do not agree with a surveyor's rating, it does not work properly since a rating is primarily subjective, and because the State has a financial incentive to keep a facility's rating as low as possible.¹¹¹

The imprecision of the rating system was perhaps the most compelling argument. Given that the homes did not completely understand what must be done in order to change or maintain ratings, they were unable to adequately adjust their behavior. This also permitted the state to tighten its reimbursement screws covertly by applying pressure on the surveyors. As we note below, this did not happen. In fact quality ratings improved.*

There was not, however, a long term problem with categorizing costs by function. Even though uniform accounting procedures were not in place, the homes would learn quickly how to maximize their Medicaid payments by switching costs from function to function until caps by function would approximate a single cap in total expenditures. This adjustment would be thwarted only by the home's inability to project what the caps might be, an unanticipated change in quality ratings or the implementation of uniform accounting.

The Hospital Association's criticism of the percentile caps as penalties for those homes above the caps itself was flawed. For example, the criticism (1) ignored the existence of the private market and charitable subsidies which permit homes to survive and even flourish when Medicaid rates are low;* (2) assumed that inefficiency must be demonstrated before limits can be placed on costs, whereas in most other economic endeavors efficiency is defined as the ability to operate successfully given the rate or price of the good, and (3) implied that the loss of any home because of "insufficient" reimbursement was intolerable.

The response to new rates was not all critiques and formal criticism. Five days after the issuance of the new rates the Metropolitan New York Nursing Home Association representing 95 nursing homes and 18,000 beds

* See pages 77-78.

** The arguments against using percentile caps are similar to the arguments against using average costs as a flat rate. For a more detailed analysis, see Spitz and Weeks, "Medicaid Nursing Home Reimbursement in Illinois." 122

in New York City said that its members would refuse to accept new Medicaid patients unless the state increased its rates.¹¹³ A representative of the association explained, "the rate the state is setting simply does not cover the cost of care. We cannot meet the health codes with these rates. We will not be party to second rate care."¹¹⁴

The state did not increase its rates and on November 10, 1976, members of the association began to refuse new Medicaid patients. The boycott was cut short when the association was found to be in violation of the state's antitrust laws by the state attorney general's office.¹¹⁵ The boycott recommendation was rescinded and the homes in the Metropolitan New York Nursing Home Association gave the state formal assurances that they would accept Medicaid patients.¹¹⁶

D. 1977: Reassessment and Task Force

1. Reassessment

By 1977, the scandals had well passed the point of outrage and public disbelief. Reforms had been implemented and the effects of those reforms had become evident. It was a period when the state recognized that it may have been too zealous in its attempt to overhaul the industry and modified some of its more stringent policies.

The 1975 and 1976 regulations were designed to force the homes to be more efficient, more prudent and careful in their accounting and cost reporting practices. In some instances, however, improved management would not create the money needed to meet financial obligations. For example, the home still had problems complying with union contracts. This lead to threats of strikes and incidents where unions placed liens on Medicaid payments to homes in order to cover benefits agreed to but not paid for by the homes.¹¹⁷

FRV also squeezed some of the homes. The Savings Banks Association of New York reported that as of March, 1977, their members had issued 180 loans to proprietary homes and 12 to voluntary facilities at a total value of \$322 million. Repayment of 36 of those loans were not current (i.e. the homes were behind in their payments) and in seven instances the banks had commenced to foreclose on owners. All of the homes in trouble were proprietary.

Table 5

Mortgages on Nursing Homes and Health Related Facilities
in New York State held by New York Savings Banks
March 1977

Preliminary Data

	Number of Loans			Balance of Loans (in thousands)		
	Total	Proprietary	Non-Profit	Total	Proprietary	Non-Profit
Total	192	180	12	\$322007	\$296705	\$25302
Non-current	36	36	0	59909	59909	0
(In fore- closure)	7	7	0	9838	9838	0
Current	157	144	12	262098	236796	25302

Source: Savings Bank Association of New York.

At one point, nearly 40 percent of the homes were at some level of default on their mortgages.¹¹⁸ Not surprisingly, the Savings Bank Association actively lobbied for reimbursement reform.

The Special Prosecutor's Office remained active. Individuals associated with approximately one-fifth of the state's 378 proprietary firms were indicted for fraud they allegedly engaged in between 1969 and 1975.¹¹⁹ The cost of the fraud was estimated at 42 million dollars.¹²⁰ What made 1977 fraud investigations different, however, was that they extended beyond the proprietary sector. The State Welfare Inspector General discovered \$2 million over-billing in one county facility for an 11 year period.¹²¹ There were "indications" that the other 54 publicly run homes had similarly defrauded the state. The over-billings permitted the public homes to pay the salaries for other county employees, building maintenance and the depreciation of buildings and equipment that were unrelated to patient care.¹²² The Inspector General estimated that \$10 to \$32 million total over payments were made to public facilities between 1967 and 1973.¹²³

On the voluntary side, the state Health Department revealed in 1977 that audits of private non-profit homes revealed over-billings of nearly \$17 million for the 1970 to 1975 period.¹²⁴ The voluntary facilities charged Medicaid for the board and keep of clergy not providing patient care as well as for unrelated property costs and depreciation.¹²⁵

These revelations discredited the assertion that profits alone were the driving force behind fraudulent behavior. Further, they may have softened attitudes of critics towards the proprietary sector. Certainly, these disclosures underscored the need to frequently audit every provider who is reimbursed on cost basis regardless of sponsor or official statement of goals and objectives.

Finally, between 1975 and 1977, ten homes had been placed in state receivership. This produced a rather embarrassing situation for the state. As a receiver, the state had a fiduciary responsibility to the owner of the home to manage his property wisely and a direct responsibility to care for the patients. In some instances, the state found its Medicaid rates were too low to permit it to meet both responsibilities.¹²⁶

2. The Joint Executive Legislative Task Force on Medicaid Reimbursement of Residential Health Care Facilities

The lower reimbursements, the audits and investigations, the political pressure from the unions and the banks, and the state's role as a receiver changed the political attitude toward the industry. Legislators and program administrators felt that disreputable operators had been driven out or, as one Senator put it, "There are no crooks left in the nursing home industry."¹²⁷ There was a sense that legitimate providers were being unreasonably squeezed by the reforms. And there was a general willingness to reconsider the current policies that had adverse effects on the industry. Part of that willingness was due to what might best be described as a post scandal relaxation of tension. Legislators and administrators could talk to representatives of the industry without fear of accusations of malfeasance of office or corruption. The improved fiscal picture in 1977 also contributed to reduced tensions.

The Executive Legislative Task Force was convened in the summer of 1977 to resolve some of the problems that state policy had created. It considered a number of reimbursement issues most of which revolved around the payment for capital and the application of quality ratings to a reimbursement system.

a. Capital Reimbursement

The Task Force accepted a set of capital cost reimbursement principles and adopted a payment methodology which represented a synthesis of the experience and work of the preceeding five years.

- (1) Appropriate and reasonable costs previously approved by the Commissioner of Health and the Public Health Council should be reimbursed.¹²⁸ This was a resolution to correct what several key state executives felt was a basic inequity of

FRV: the unilateral change in policy by the state which left many nursing homes in the breach. As Morton Hyman, Chairman of the Task Force noted:

There are facilities that have been built with the approval of the Commissioner, with the approval of the Public Health Council, where leases and capital costs have been approved, where obligations have been undertaken, where the cost was reasonable...and where there was no malfeasance...some way or another you have to pay those costs. ¹²⁹

- (2) The state should pay for a facility only once, minimize the state's annual expenditures and minimize the risk to mortgages.^{ees 130} Each of these conditions were mutually dependent and resulted in a refined version of the regulations adopted in 1975.

Paying for a facility once meant that the state would not recognize financial transactions (e.g., sales, leases, etc.) which did not physically alter or improve the facility. It also implied that the state would treat each home as if it had one life, i.e., as if it were self-liquidating concern.* Each facility was assigned a 40 year life The 40 year figure was derived from the American Hospital Association's Estimated Lives of Depreciable Hospital Assets.

* Renovation and additions would be treated as a new facility and reimbursed accordingly.

Concern over minimizing the state's costs and the mortgage's risk meant that the state would reimburse the actual debt service (amortization and interest expenses) up to a limit and the state would fund "excess" reimbursements. The process worked in the following way. Each year 2.5 percent of the original cost of the facility may be reimbursed. If the amortization was less than 2.5 percent, then the difference between amortization and 2.5 percent of the cost of the facility was "funded" by the state; that is, the state did not actually set aside the funded amount but credited it to the home's account. Over time a home's yearly amortization exceeds 2.5 percent of its original cost. The home would then be able to draw off its fund. Table 6 shows how amortization would be reimbursed under conditions where mortgages varied by interest rates (9.0 percent and 12 percent) and the original terms or life of the mortgage (15, 20 and 25 years). As can be seen in these examples, as the original term of the mortgage is lengthened the time period that state's payments will meet mortgage payments in also increased. Further, as interest rates increase, the rate at which the mortgage is amortized decreases and the time for Medicaid's total coverage of mortgage payments is increased.

This form of capital reimbursement postponed the time when refinancing was necessary as well as the number of times a home was forced to refinance. Refinancing normally occurs when reimbursement covered only a portion of the yearly amortization. By renewing the loan, the home increased the portion of the debt service attributable to interest expenses and reduced the portion amortized. By limiting amortization to an average of 2.5 percent of the original cost, the state forced the home into ^{an extended} ~~a 40-year~~ payoff strategy, but it did not necessarily force the homes to refinance only after they "exhausted"

TABLE 6

YEARLY AMORTIZATION REIMBURSED UNDER NYS-77*

INTEREST RATE		9.0%			12.0%		
ORIGINAL LENGTH OF THE MORTGAGE IN YEARS	15	20	25	15	20	25	
ACTUAL AGE OF THE LOANS IN YEARS							
1	**3.31	1.87	1.12	*2.54	1.28	0.68	
2		2.05	1.22		1.45	0.76	
3		2.24	1.33		1.62	0.85	
4		2.45	1.46		1.84	0.97	
5		2.68	1.60		2.07	1.09	
6		2.94	1.74		2.32	1.22	
7		3.20	1.91		2.13	1.38	
8		**3.51	2.09		2.96	1.56	
9			2.29		3.33	1.76	
10			2.50		3.75	1.97	
11			2.74		4.23	2.23	
12			2.99		**4.77	2.51	
13			3.27			2.83	
14			3.58			3.19	
15			3.91			3.59	
16			4.28			4.05	
17			**4.69			4.56	
18						5.14	
19						5.77	
20						**6.52	

* Percent of principal amortized for the first mortgage at 100 percent of the value of a new facility

** Only a portion of the amount amortized will be reimbursed

the Medicaid funded amount. Separate federal tax incentives may encourage owners to refinance before a home had used up its Medicaid funded payments.¹³¹

Finally, by gearing reimbursement to actual debt service, the state gave greater assurance to the mortgage^{ees} ~~ors~~ that loans will be repaid while at the same time it eliminated the possibility that owners might pocket excess depreciation--an occurrence that often took place under the pre-1975 reimbursement system. The state's concern and commitment to minimizing the risk to the banks was based on the belief "that the state has an ongoing responsibility to the patients in (a) facility and that the entire planning concept of the state is predicated on the fact that the homes that are approved and open will continue to operate...(If) these facilities (are) foreclosed...you run the risk of serious disruption of the delivery of services...you may have to close down beds...(and) the bank may demolish the facility (and) take it out of the health care system."¹³²

b. Operating Costs

The Task Force considered the quality/reimbursement link as the major operating cost issue. Problems were reviewed concerning the definitions of quality, the use of those definitions for reimbursement purposes and the ability of the home to improve its care. It was conceded that the state did not have a precise definition of quality. This lack of precision (compounded by the subjective application of those standards) had upset the industry and the legislature because it was felt that the system was unable to distinguish between various levels of good homes (very good, good-state, and good-federal). This meant that some homes were being arbitrarily rewarded or penalized. The lack of refinement in the quality measures made ratings

by functions even more difficult to justify. The dual classification of poorer facilities as either needs improvement or unacceptable had produced a stir in HEW. Specifically, HEW felt that if a home was "unacceptable" the federal government should not contribute anything to the care provided in that facility.¹³³ This would have increased the state's portion of the payment.

The classification problems were resolved by collapsing the five quality ratings into three: very good, satisfactory and needs improvement. It was argued that this was easier to defend, was more acceptable to the industry and "semantically" avoided HEW's uneasiness with labelling a facility unacceptable.¹³⁴ It also maintained a tiered system with incentives to improve quality (although the incentive to move from satisfactory to very good was not very strong in practice).

The limits by function were eliminated in favor of a total limit. The change was justified in part because of inequities that arose with the lack of uniform accounting and also because of the enormous administrative burden the state assumed. But the position that limits had to exist was accepted by the Task Force as prerequisite to cost control.

There was no consensus within the Task Force over the impact that the reimbursement methodology was having on quality. The legislative members voiced the industry's argument that over time, the 1976 system would reduce the quality of care. The Department of Health did not think that the short term effects suggested a drop in quality. It was observed that in 1976 the five homes that had very good ratings generally had lower costs than homes with good-state and good-federal ratings.¹³⁵ Second, there was large

TABLE 7

RESIDENTIAL HEALTH FACILITY QUALITY RATINGS

	<u>Nursing Homes</u>			<u>Health Related Facilities</u>		
	<u>1976</u>		<u>1977</u>	<u>1976</u>		<u>1977</u>
	<u>#</u>	<u>%</u>	<u>#</u>	<u>#</u>	<u>%</u>	<u>%</u>
Very Good	4	.7	4	1	.4	.8
Good State	392	60.3	434	156	68.4	85.1
Good Federal	153	28.1	67	52	22.8	10.5
Needs Improvement	42	7.7	23	16	7.0	3.5
Unsatisfactory	<u>17</u>	<u>3.1</u>	<u>9</u>	<u>3</u>	<u>1.3</u>	<u>0</u>
	545	100	537	228	100	100

Source: Department of Health, 1977

improvement in the quality ratings between 1976 and 1977. Homes either stayed at the same level or improved. Not one home in 1977 was rated below its 1976 level. As Table 7 shows, the number of good-state SNFs jumped from 392 in 1976 to 434 in 1977 and good-state HRFs went from 156 to 195. By 1977, 81.5 percent of the SNFs and 85.9 of HRFs were good-state or better. Either homes had the resources to improve the quality of their care or surveyors were more lenient in 1977. In either case, the reinforcing cycle of rapid deterioration of quality and decreases in reimbursements predicted by the New York Hospital Association did not occur. Thus, it was felt that limitations by quality would not have a deleterious effect. Regulations were recommended and adopted which reimbursed "very good" homes at higher level of either their group average per diem or 110 percent of a similar "satisfactory" group of homes. Satisfactory homes were reimbursed up to their group average. "Needs improvement" homes received the lower of their group average and 90 percent of a comparable "satisfactory" group.

The Task Force also addressed the role and use of management assessments--the state's interdisciplinary team review of a nursing home's operation. An assessment could be requested by a home if it felt the Medicaid rate was insufficient. Since the only costs that could be reviewed were operating costs, management assessment became an exceptions process for operating costs.

During 1977, there was an enormous backlog of homes requesting management assessments. Since a positive recommendation from the management assessment team meant a home's rate could be increased, it was in the interest of every home to apply for an assessment. In fact, only half the facilities did so.¹³⁶ The initial problems with the management assessment process rested with the fact that it was modeled after a hospital quality survey, that the assessment methodology was not very sophisticated and that the state teams were untrained and inexperienced in performing productivity studies.¹³⁷ In addition, the lack of

manpower to do the assessment brought forth charges by the industry that management assessment was merely a stalling device which allowed the state to set and maintain rates at insufficient levels.¹³⁸ Given that management assessments were first mandated at the end of 1976 and that by mid-1977 only 20 of the nearly 600 requested assessments had been completed, the industry's disquiet was understandable.¹³⁹

There was also a programmatic dispute over the function of the management assessment. Some on the Task Force argued that it should have served as a guide to improving quality. Others argued that it should have acted as an efficiency tool for homes providing satisfactory care. It was feared that if management assessments were used primarily as a stepping stone to higher quality, that the costs incurred would be prohibitive.¹⁴⁰ The issue was not resolved and the changes in the 1977 regulation regarding the management assessments were ambiguous on this point. In the words of the 1977 regulations, the purpose of the management assessment review was to "consider the quality, type and intensity of care required by the patient population....and the efficiency with which the care is delivered."¹⁴¹

E. 1974-1977: Observations

Four general observations can be made about this period and the state's problems with and policy towards the industry. First, our review of the reimbursement system focused on the methodologies employed, their advantages and disadvantages and the changes and adjustments. The major weakness of the 1974 system, however, was that it encouraged fraud. At that time, the state auditing staff was too small to review and examine the industry's financial statements and reports. There were no penalties if costs were overstated. Confusion was enhanced because of a lack of uniform accounting and cost allocation systems. And yet, rates were based on each individual home's costs. It was an unstable and evidently tempting situation.

Initially, the state did not realize how tempting. The state assumed that the profit motive would be the only incentive for fraud. The state limited its initial investigation to the proprietary sector and discovered as estimated \$42 million of fraud for the 1969-1975 period. The state expanded its investigations and found that government facilities had "overpaid" \$10 to \$32 million between 1967 and 1973 and that voluntary homes had similar "overpayments" of \$17 million for 1967-1973. The state had, by the end of 1977, changed its laws, substantially increased its auditing capacity and created and staffed a strong investigative unit within the Attorney General's Office. The fact remains, however, that fraud or "overstatement of costs" should be expected on the part of all types of providers when the reimbursement system is based upon each home's costs and when the state monitoring is ineffective.

Second, while the scandals may have had more media coverage than the 1976 fiscal crisis, the fiscal crisis had a much bigger impact on the reimbursement rates and methodology. The fiscal situation forced the state to live with less and to structure its reimbursement system to accommodate this condition of scarcity. Beyond FRV, the scandals did not provoke as clear a direction for change in the payment mechanism as did the fiscal squeeze. And FRV, itself, was a modified extension of the existing policy for new facilities to all proprietary facilities.

The brief experimentation with FRV was as much a test of the ability of the state to impose rapid comprehensive change as it was an experiment with capital reimbursement. One result of that experiment was that it demonstrated how financial arrangements carry with them a sort of political and economic inertia which bind related institutions to each other. Major changes in the financial situation of one institution affects all the related organizations. The resistance to change then extends to all groups affected.

Cut backs in the dollar amount that the state payed for capital did not just affect the nursing home operators; for the operators were unwilling to absorb all the costs. It affected the nursing home employees, the banks and lending institutions and the patients. These groups responded by applying considerable political and legal pressure. Wholesale change was resisted and the state was unable to counter that resistance. An incremental approach was the only politically acceptable alternative.

Finally, the period was characterized by claims by the nursing home associations that inadequacies in the reimbursement system would cause wide-scale default on property taxes, abandonment in poor communities, deterioration in the quality of care and rapid decline in the number of homes and beds. In fact, between January 1975 and October 1976, 11,330 nursing home beds were opened, 8,694 beds were closed for a net gain of over 2,800 beds. Surprisingly, the majority of beds that opened were proprietary. (See Table 4 .) Thus, during the heat of the scandals and investigations when the state was purging itself of undesirable operators and carefully examining the for-profit sector, the returns to owning and operating a home were high enough to not only encourage growth in the industry but growth among the proprietary sector as well. Further, the quality of care disaster that the industry predicted must have eluded the state's surveyors. As shown in Table 7, quality levels actually increased between 1976 and 1977.

IV. Trends in New York's Reimbursement Systems

The New York reimbursement system underwent a number of changes during the 1974-1977 period. In this section we will attempt to identify major trends, and then indicate how those trends address the reimbursement issues raised in Section I. As shown in Tables 8, 9, and 10, there were four methods of capital cost reimbursement and three for operating costs during the study period. Yet, for all the changes that occurred, certain characteristics of the reimbursement system remained constant. The rates were prospectively determined for each home. Each facility's individual cost experience (subject to certain limitations) was the basis for reimbursement. Historical costs were an integral component of the capital reimbursement systems. The cost experience of nursing homes grouped according to similar characteristics was the basis for setting screens. Care levels (SNFs and HRFs) and bed size were the only common group characteristics used throughout the period. Each home was assigned a useful life of 40 years. And the Medicare Rate of Return was the common index for determining a return on capital.

For all that remained the same, there were many changes and several trends. A number of the changes were transitory. For example, the homes were segregated by sponsorship (proprietary and voluntary) for operating costs in 1974 and for operating and capital costs after FRV was adopted in March, 1976. When the system changed in October, 1976, the proprietary/voluntary distinction applied only to capital costs. That distinction was eliminated in 1977. The use of cost centers for operating costs is another case. In 1974, three cost centers (administration, dietary, and housekeeping) were grouped to derive a ceiling on costs in addition to a

CAPITAL COST REIMBURSEMENT

1. APPLICATION OF RATE METHODS		1974 EXISTING AND NEW FACILITIES		1975 EXISTING FACILITY RATES FROZEN METHODOLOGY APPLIES ONLY TO NEW FACILITIES		1976 EXISTING AND NEW FACILITIES	
II. DEPRECIATION/INTEREST/RATE OF DEPRECIATION							
A. BASE	ORIGINAL COST OF BUILDING AND FIXED EQUIPMENT, IF SALE; UNDEPRECIATED REPLACEMENT VALUE	STRAIGHT LINE	40 YEAR	ORIGINAL COST OF BUILDING, FIXED EQUIPMENT	STRAIGHT LINE	40 YEAR	EXISTING FACILITIES: BOOK VALUE USED BY DEPT. OF HEALTH OR ESTIMATED "REASONABLE VALUE." NEW FACILITIES: BUILDING COST.
B. METHOD							
C. LIFE							
D. LIMITS				SALES AND/OR LEASES NOT RECOGNIZED DEPRECIATION IN EXCESS OF AMORTIZATION FUNDED 2.5% OF ORIGINAL COST OF LAND REIMBURSED ANNUALLY	SALES AND/OR LEASES NOT RECOGNIZED		FUNDING REQUIRED RECAPTURE PROVISION ON SALE IF PROPRIETARY SOLD TO VOLUNTARY, UNDEPRECIATED/REPLACE- MENT WITH RECAPTURE SETS VALUE
E. INTEREST							
PREVAILING RATES INTEREST EXPENSE ON PORTION OF LOANS IN EXCESS OF 75% OF BOOK VALUE NOT RECOGNIZED		PREVAILING RATES INTEREST EXPENSES ON LOANS IN EXCESS OF BOOK VALUE NOT RECOGNIZED		INTEREST RATE SET EQUAL TO MEDICARE RATE OF RETURN. MEDICARE RATE OF RETURN RECALCULATED EVERY 10 YEARS (5 YEARS MOVING AVERAGE)		INTEREST RECOGNIZED BY DEPARTMENT UNDER NYS-74.	
III. RATE OF RETURN							
A. BASE	BOOK VALUE MINUS DEBT ON OUTSTANDING PRINCIPAL	PROPRIETARY ONLY		BOOK VALUE (UNDEPRECIATED PORTION OF ORIGINAL COST) MINUS ALL DEBT ON CAPITAL		VALUE OF LAND; IF LAND HAD BEEN USED FOR NURSING HOME FOR LESS THAN 20 YEARS IT EQUALS BOOK VALUE; IF MORE THAN 20 YEARS INFLATED	
B. RATE	MEDICARE RATE OF RETURN	MEDICARE RATE OF RETURN		MEDICARE RATE OF RETURN (GNP DEFLATOR) (1/3)		EQUALS PRV PROPRIETARY RATE	
IV. LEASES							
ARMS LENGTH: MAXIMUM EQUATED PRE-MEDICAID RATE INFLATED BY DODGE CON- STRUCTION INDEX AND COST OF MORTGAGE MONEY. NON-ARMS LENGTH: MAXIMUM EQUATED 80 PERCENT OF ARMS LENGTH MAXIMUM, 56 PERCENT OF ARMS LENGTH MAXIMUM FOR CONVERTED BUILDINGS		NOT RECOGNIZED		NOT RECOGNIZED			

TABLE 9

CAPITAL COST REIMBURSEMENT

	1976	1977
	<u>Proprietary</u>	<u>Voluntary and Public</u>
BASE	APPROVED BOOK VALUE OF BUILDING AND FIXED EQUIPMENT. IF COST DATA UNAVAILABLE A VALUE IS ASSIGNED BASED ON APPROVED BOOK VALUES OF COMPARABLE FACILITIES	CERTIFIED ORIGINAL COSTS APPROVED BY STATE; COSTS APPROVED BY STATE; OR INPUTED COSTS TO FACILITIES (1) WITHOUT COST DATA (2) WITH NON-RECOGNIZED LEASES AND (3) BUILT PRIOR TO BUT OPERATED AFTER THE IMPLEMENTATION OF ELT-77
METHOD	STRAIGHT LINE	SEE LIMITS
LIFE	40 YEARS	40 YEARS
LIMITS	BOOK VALUE MAY BE REDUCED TO DISALLOW PRIOR TRANSACTIONS AND TO ADJUST FOR HOME'S AGE, SIZE, LOCATION AND CONDITION AND CONDITION. SALES/LEASES AFTER 3/75* NOT RECOGNIZED. MINIMUM \$200 PER BED.	PRIOR TRANSACTIONS FOUND TO BE "OTHER THAN FAIR OR REASONABLE" DISALLOWED. SALES OR LEASES AFTER 3/75* NOT RECOGNIZED. STATE "FUNDS" DIFFERENCE BETWEEN AMORTIZATION AND 2-1/2% OF FACILITY'S COST. AVERAGE PAYMENT MAY NOT EXCEED 2-1/2% MINIMUM PAYMENT EQUALS 1/2 PAYMENT RECEIVED IN FINAL YEAR OF FACILITY'S "USEFUL LIFE."
INTEREST	MEDICARE RATE OF RETURN RECALCULATED EVERY 10 YEARS (5 YEAR MOVING AVERAGE)	PREVAILING RATE
RATE OF RETURN BASE	COST OF LAND WHEN FIRST USED FOR NURSING HOME CARE	PROPRIETARY ONLY: ASSETS NET OF LIABILITIES INVESTED IN LAND AND BUILDING AMORTIZATION PAID BY STATE EXCLUDED.
RATE OF RETURN	REASONABLY RELATED TO MONEY MARKET	MEDICARE RATE OF RETURN
LEASES	IF LEASES ARE NOT "FAIR AND REASONABLE" THE HOME IS TREATED AS IF IT WERE AN OWNED FACILITY WITHOUT COST DATA (ABOVE). PAID IF (1) HOME LEASED PRIOR TO 3/75 (2) LEASE IS "BONA FIDE, VALID AND NON-CANCELLABLE" AND (3) THE TERMS ARE REASONABLE.	PAID IF (1) LEASED PRIOR TO 3/75* (2) LEASE IS "BONA FIDE, VALID AND NON-CANCELLABLE," AND (3) PROPERLY DETERMINED ACCORDING TO REGULATIONS IN FORCE AT THE TIME THE LEASE WAS SIGNED. AT COMMISSIONER'S DISCRETION, A LEASE MAY BE RECOGNIZED IF THERE IS "PUBLIC NEED."

* PUC-75 IMPLEMENTED IN 3/75 DID NOT RECOGNIZE SALES OR LEASES.

Table 10

OPERATING COST REIMBURSEMENT PROCEDURES

1974

GROUPING
CARE LEVEL: SNF, IIRF
BED SIZE: LESS THAN 50, 51-99, 100-199, 200-299, 300+
LOCATION: HOSPITAL SERVICE AREAS OF NYC, ROCHESTER, WESTERN N.Y., CENTRAL N.Y., NORTHEAST, LONG ISLAND, NORTHERN METROPOLITAN
SPONSORSHIP: PROPRIETARY, VOLUNTARY, GOVERNMENT.

LIMITATIONS
110% OF AVG. COMBINED PER DIEM GROUP COSTS FOR ADMINISTRATIVE, DIETARY, & HOUSEKEEPING SERVICES. 115% OF AVG. TOTAL PER
DIEM GROUP COSTS EXCLUDING PROPERTY COSTS. THERAPY, DRUGS & RETURN ON EQUITY. HkF's CANNOT EXCEED 60% OF SNF IN
COMPARABLE GROUP. SPECIFIC LIMITS ALSO PLACED ON ADMINISTRATIVE SALARIES AND COSTS, MOVEABLE EQUIPMENT AND COSTS INCURRED
IN DEALINGS WITH RELATED COMPANIES. IIM-15 LIMITS APPLIED WHEN STATE RULES NOT SPECIFIED.

RATE REVISIONS
UNION CONTRACTS (WAGES, SALARIES AND FRINGE BENEFITS). RAPID CHANGES IN FACTOR MARKETS. COSTS ASSOCIATED WITH NEW SERVICES,
IMPROVEMENT IN QUALITY, ANTICIPATED EFFICIENCY IMPROVEMENTS, & LONG TERM COSTS SAVINGS.

MORELAND ACT COMMISSION RECOMMENDATION: NEVER ADOPTED

GROUPING
NURSING HOME COSTS BROKEN DOWN BY COST CENTERS WOULD BE REGRESSED IN A NUMBER OF INDEPENDENT VARIABLES (SIZE, PATIENT MIX,
LOCATION, ETC.) ALL THE RELEVANT VARIABLES WERE NOT SPECIFIED. EACH HOME WOULD HAVE ITS INITIAL RATES SET FROM THE
REGRESSION ESTIMATED COSTS.

LIMITATIONS
HOMES WITH LOW COSTS AND ACCEPTABLE CARE IN ONE OR MORE COST CENTERS WOULD BE USED TO SET EFFICIENT CARE STANDARDS OF COST
AND WOULD BE USED TO CHANGE INITIAL RATES. CEILINGS WOULD BE SET ABOVE EFFICIENT CARE STANDARDS TO PERMIT THE INDUSTRY
TO ADJUST, COVER NECESSARY COSTS NOT INCLUDED IN THE STANDARDS AND PROVIDE INCENTIVES. COST MUST BE LINKED TO MEASURES
OF ACCEPTABLE CARE (TO BE DEVELOPED). DURING INTERIM USE SURVEY INSTRUMENTS AND PMR.

RATE REVISIONS
NOT SPECIFIED.

1976

GROUPING
CARE LEVEL: SNF, IIRF
BED SIZE: LESS THAN 50, 51-99, 100-199, 200-299, 300+
FUNCTIONS: NURSING, NUTRITION, LIESURE, CLEANLINESS AND SAFETY, SOCIAL WORK, ADMINISTRATION.
QUALITY: VERY GOOD, GOOD STATE, GOOD FEDERAL, NEEDS IMPROVEMENT, UNACCEPTABLE.

LIMITATIONS
NO LIMITS VERY GOOD FUNCTIONS, ALL OTHERS CAPPED: GOOD STATE EQUAL 60th PERCENTILE OF THAT GROUP, GOOD-FEDERAL THE 35th
PERCENTILE OF GOOD-STATE GROUP, NEEDS IMPROVEMENT 25th PERCENTILE OF GOOD-STATE GROUP, UNACCEPTABLE 10th PERCENTILE OF
GOOD-STATE. UNACCEPTABLE CARE RATE REDUCED ADDITIONAL 10%. HOMES NOT PARTICIPATING IN MEDICARE HAD RATES REDUCED 10%.
OVER STATED COSTS CHARGED 7%, IF WILLFUL A PENALTY OF 1/4 OVER CHARGES APPLIED. ADMINISTRATIVE COSTS NOT TO EXCEED 50th
PERCENTILE OF BED SIZE GROUP IIM-15 LIMITATION IN EFFECT WHERE APPLICABLE.

RATE REVISIONS
ERRORS IN RATE COMPUTATION: HOME IMPLEMENTS NEW PROGRAMS OR ADDS STAFF AND SERVICES MANDATED BY THE STATE: THE HOME MAKES
CHANGES WHICH LOWER COSTS: THE HOME DEMONSTRATES "APPROVED SERVICES, PATIENT MIX, AND LENGTH OF APPROXIMATE STAY" THE
CAUSE FOR COSTS IN EXCESS OF THE CEILING

1977

GROUPING
CARE LEVEL: SNF, IIRF
BED SIZE: LESS THAN 50, 51-99, 100-199, 200-299, 300+
QUALITY: VERY GOOD, SATISFACTORY, NEEDS IMPROVEMENT
LOCATION: NEW YORK CITY, NEW YORK SUBURBAN, UPSTATE
URBAN, UPSTATE RURAL

LIMITATION
THE COST CENTERS FOR NURSING, NUTRITION, LIESURE, CLEANLINESS, SOCIAL WORK, AND ADMINISTRATION ARE SUMMED. AFTER ADJUSTING
FOR OUTLIERS, HOMES WILL BE PAID A MINIMUM OF 75% OF THEIR GROUP AVERAGE AND A MAXIMUM OF 125%. "VERY GOOD" GROUP AVG.
RECEIVES THE HIGHER OF THEIR AVG. PER DIEM & 110% OF COMPARABLE SATISFACTORY GROUP. "NEEDS IMPROVEMENT" GROUP THE
LOWER OF THEIR AVG. PER DIEM & 90% OF SATISFACTORY. 300+BED GROUP CAN NOT EXCEED 110% OF 200-299 BED SIZE GROUP. HOMES
WITH "UNACCEPTABLE LEVEL OF CARE" HAD 10% REDUCTION IN THEIR RATES. HOMES NOT PARTICIPATING IN MEDICARE HAD 10% REDUCTION
IN RATES. IIM-15 LIMITATIONS WHERE APPLICABLE.

RATE REVISIONS
ERRORS IN RATE COMPUTATION. OVER-ALL INCREASES IN OPERATING COSTS FROM ADD-ONS SPECIFICALLY MANDATED OR APPROVED BY STATE.

ceiling on total operating costs. In 1976, costs were divided among six cost centers (nursing, nutrition, leisure, cleanliness and safety, social work and administration), and separate screens were applied to each center. One year later all the cost centers were collapsed into one category of total operating costs.

Trends, however, did emerge out of the reimbursement activity. In terms of capital cost reimbursement, the trends were towards using only historical costs; phasing out any reimbursement distinctions based on whether a facility was owned or leased, held or sold; reimbursing debt service only; and, requiring funding for all facilities. In terms of operating costs, the trends were towards having fewer characteristics for grouping homes; less variations in the screens and a definition of efficiency that measured homes by their performance relative to their group's cost experience and their evaluation by management assessment teams.

A. Capital Costs

As noted earlier, the critical issues for reimbursing capital were related to placing a value on the property, resolving policy towards different ownership arrangements and histories and establishing how much control the state should have over its payments for the services of nursing homes' capital. The state began paying homes on a cost basis in 1967. By 1974, the state had nearly "perfected" a system which attempted to treat homes as equitably as possible. The homes had three options: depreciation/interest/return on equity, arm's length rental and non-arm's length rental. Each method attempted to accommodate special problems. New expensive homes did well using the depreciation method, older homes and low cost homes received a larger return under one of the imputed rental approaches although a distinction was drawn between leases drawn between related and non-related parties and buildings converted into nursing homes and those built

as nursing homes. Each time a new distinction was drawn, complexities increased as did the potential for provider manipulation.

The trend toward complexity peaked in 1974 and was reversed the following year. By 1977, the state's new approach to capital cost reimbursement had become clear. Historic costs became the only way to set the base value of the facility. (Although during the transition, other cost methods used by homes prior to 1975 have been accepted. The rates, however, could not be increased under any other method but the historical cost approach.) Reimbursement distinctions based on whether a facility was leased or owned, held or sold, were being phased out. Only debt service would be paid. Finally, the state would fund excess depreciation.

Historical costs were selected for a variety of reasons. It was a generally less expensive means for setting the value of a home than the replacement on the market value approach. It was consistent with the view that the home is self-liquidating and that the capital was being used up continually. The only way to increase reimbursement was to modernize or renovate. Each improvement was treated as part of a new facility and assigned a historic cost and useful life.

The use of historic costs has three problems. First, it is complicated to administer. Each time a home renovates, it essentially built a portion of a new home to be paid off. Any single home might have "15 or 20 different homes" in it.

Second, despite modest renovation, it is highly probable that as facilities get older, the historic costs become less closely aligned with its replacement value. Since most homes are so highly dependent on Medicaid, the historic costs become an unaltered price of the home regardless of market

activity in other parts of the real estate market. The only way that the price of a home might reflect private market conditions would be if it had a relatively large private pay population (which would pick up the cost for appreciation) or if it was taken out of production as a nursing home and the land was used for another purpose. Conversion has its own problems. First, the home may have to gain state approval before it could stop being a home. Second, the price the land will bear will be a function of the market value of similar parcels of land minus the cost to demolish the home and prepare the land or the cost of converting a single purpose structure. Thus, as time goes on, the decline in the value of the home relative to market activity and the difficulty of converting to another, may discourage proprietary investment in homes and cause the supply of beds to decline. This may not apply to non-profit institutions, some of which may be indifferent to the declining value of their home.

Finally, while historic costs was the least expensive approach, it does not prevent reimbursement for homes whose costs are two or three times the state's average cost per bed. Control over the initial costs of a home rests with the Public Health Council, the agency responsible for issuing certificates of need. Thus, although Medicaid will probably pay for more than 75 percent of the property, the Medicaid rate setting authority does not place limits on the initial cost of a nursing home.

Phasing out reimbursement distinctions based on ownership arrangements or ownership history can be viewed as a move towards setting a price for the services of capital (rather than trying to tie reimbursement to the continually changing capital costs of a facility). It can also be viewed as eliminating the expensive financial implications and politically sensitive repercussions that can accompany trafficking, sale/leasebacks, and unchecked

refinancing. Homes could engage in these practices but they would no longer be reimbursed for them.

The payment of debt service only and establishment of a state funding mechanism is a rather elegant solution to the problem of reimbursing on the basis of costs. Together, these mechanisms eliminated the depreciation bonus payments the home had received in the past when amortization was less than depreciation.* Amortization only would be paid. The decision to pay amortization only creates problems when the homes have mortgages shorter than the 40 year useful life assigned to the home by the state. This would cause the state to pay off homes before the homes had been physically used up and to retire loans for owners with undue haste. New York solved this problem by setting up a "fund" for each home. When the home's amortization payments were less than two and a half percent of the building, the difference would be credited to the home. In later years, when the home's amortization exceeded depreciation, the home could draw from its account but never beyond the point where the average per annum payment made by the state exceeded two and a half percent of the cost of the building. By doing the funding itself, the state was able to defer making cash payments to the homes, minimized the discretion that operators had over capital funds and provided a mild guarantee to mortgagers that state money intended to pay off mortgages would in fact be used for that purpose.

It is difficult to identify how this method of reimbursement will affect the industry. It is certainly less lucrative than the systems that preceded it. Those operators and owners who were after and received high

* Simply stated, state payments had equalled depreciation plus interest. The homes' mortgage payments equalled amortization plus interest. During the early years of a mortgage, payments are mostly interest. Amortization is very low. Depreciation is usually greater than amortization and the difference between the two is sheltered or untaxed. The amount amortized increases slightly with each payment. At some point usually half-way through the life of the mortgage, amortization exceeds depreciation. That point is determined by the interest rate, the length of the mortgage, whether the mortgage is partially or fully amortizing and the depreciation techniques employed. For a more elaborate discussion, see pages 8-18.

rates of return on their investment will probably attempt to switch out of nursing homes altogether. Homes with very high capital costs will have their books reviewed and the state will determine how reasonable the rates are. All other homes will be grandfathered in at their pre-1975 rates or at their historic costs. The use of historic costs carries with it a bias towards newer homes and might lead to early deterioration and decline in the bedstock. Other possible industry responses cannot be easily discerned from the reimbursement system. It is not readily apparent, for example, whether any homes in a given size range, geographic location, a sponsor status will benefit. Rather, this payment method should be viewed as a means for placing a cap on future payments and easing the industry into that future.

B. Operating Costs

Operating cost reimbursement has undergone several important changes. The number of characteristics for defining groups has been slightly reduced and slightly altered. The most important change, however, is that cost screens have converged around average group costs and the impact of the very expensive and very inexpensive homes on the group averages has diminished. In 1974, homes were disaggregated by care level, bed size, location and sponsorship. Homes were subjected to two screens. Costs were disallowed if they were in excess of 110 percent of the average combined group per diem for administration, dietary and housekeeping or 115 percent of the average total operating cost. In 1977, the homes were grouped by care level, bed size, location (four regions as opposed to the seven in 1974) and quality of care (very good, satisfactory and needs improvement). The weighted average costs for each group were determined.

Those homes with costs in excess of 125 percent of the average or less than 75 percent of the average were imputed costs at 125 percent or 75 percent of average costs and the average was recalculated. This lessened the impact that outliers had on the average. Once this was done an adjustment was made for quality, that is, very good homes could incur costs up to their group average or 110 percent of a comparable group of Satisfactory homes, whichever was higher. Needs improvement homes on the other hand, received the lower of their group average or 90 percent of a comparable group of Satisfactory homes. This methodology continued to disaggregate facilities by bed size and thus did not provide an incentive for members of the industry to seek out the most efficient scale of operations. This approach, however, probably lessened the extreme variation in cost between voluntary, public and proprietary homes. Also, it probably will result in higher costs for higher quality homes regardless if those quality standards necessarily require increased expenditures. Thus, given the "quality" incentives in this system, the confounding instances of very good homes with lower costs than satisfactory or needs improvement homes should disappear over time.

FOOTNOTES

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6. Richard I. Ratcliff, Current Practices in Income Property Appraisal: A Critique, Berkley, California, The Center for Real Estate and Urban Economics, University of California, 1964.
7. American Health Care Association, How Medicaid Pays for Long Term Care, Washington, D.C., American Health Care Association, 1978.
8. I am indebted to John Holahan for drawing out these arguments.
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16. Ibid, pp. 42-43.
17. Ibid.
18. Ibid, p. 54.
19. Ibid, p. 9, 43-44.
20. Ibid, p. 45-46.
21. Ibid., p. 9.
22. New York Department of Health, Unpublished Data, undated.
23. Ibid.
24. Bureau of Data Management and Analysis, New York Department of Social Services. The nursing home costs include costs for ICFs, SNFs and Medicaid payments to institutionalized mental hygiene patients.
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26. The description of the capital reimbursement system is extracted from Moreland Commission, Reimbursement of Nursing Home Property Costs, pp. 18-27.
27. Stein Commission Report, pp. 29-32.
28. Ibid, p. 32.
29. Spitz and Weeks, "Medicaid Nursing Home Reimbursement in Connecticut," pp. 53-55.
30. Commerce Clearing House, Inc., Medicare and Medicaid Guide (Chicago: Commerce Clearing House, October 1977), paragraph 5682, p. 1883.
31. Moreland Commission, Reimbursement of Nursing Home Property, p. 138.
32. Ibid., p. 139.

33. The description of operating cost reimbursement is extracted from Moreland Commission, Reimbursing Operating Costs, pp. 24-37.
34. Moreland Commission, Reimbursement of Nursing Home Property Costs, p. 121.
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39. Ibid, p. 121.
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41. Ibid, Moreland Act Commission, Reimbursing Operating Costs.
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ILLINOIS



Table of Contents

I.	Introduction	1
II.	The Illinois Nursing Home Industry	2
III.	The Development of Reimbursement Policy	8
	A. Scandals and Improved State Regulation	8
	B. Kickbacks, Sheltered Care Upgraded and Boycott	12
	C. A Critique of the Boycott Charges	15
	D. The Cost Related System	20
IV.	Economic Analysis	24
	A. General Incentives - Uniform Flat Rate	24
	B. The Illinois System	35
	Footnotes	58
	Appendix -- Illinois Cost Related Reimbursement for Skilled Nursing and Intermediate Care Facility Services	

I. Introduction

Medicaid nursing home reimbursement policy in Illinois has developed in response to generally conservative fiscal state policies and a preference among state officials for linking a measure of patient debility with payment. The policy and the reimbursement system have remained unusually stable. From its inception in 1967 to 1978 when it was incorporated into a cost related system, Illinois' point count reimbursement remained basically unaltered. It consisted of a base rate (adjusted for special services) and point rate derived from an evaluation of the patients level of debility. The stability of the system was due in part to quality of care scandals in the early 1970s which led to innovative and active monitoring of care but which also directed attention away from the payment mechanism. Stability was also related to the point count's "flexibility". This allowed providers to survive and expand even though rates were effectively frozen for extended periods of time.

The new cost related system uses the "point count" to reimburse nursing costs only. The remaining operating costs are reimbursed up to the cost experience of the 50th percentile of skilled care and intermediate care facilities within a given geographic area. Capital costs are determined by aggregating homes by age and location and reimbursing according to the group experience within each cell. The implications of this policy on the nursing home sector are discussed in Section III of this paper. This analysis suggests that over the long run, reimbursement according to these principles will produce a smaller, more efficient industry.

II. The Illinois Nursing Home Industry

In 1977, there were 939 long term care facilities with 97,620 beds in Illinois. The 364 homes classified as skilled nursing facilities (SNFs) represented 38,678 licensed beds; 400 Intermediate Care Facilities (ICFs) and 175 Sheltered Care Homes accounted for 58,051 licensed beds. In addition, 891 beds had provisional licenses (see Table 1). SNFs ranged in size from 21 to 324 beds, ICFs from 8 to 300 beds, and sheltered care from 5 to 704 beds.¹ The average size for SNFs was 106 beds and 101 beds for ICFs with 61 percent of all facilities under 99 beds (see Table 2).

Ownership patterns reflect domination by the proprietary sector; nearly 82 percent of the facilities are for profit, 14 percent are private-non-profit, and slightly more than four percent are run by county governments (see Table 3).

As might be expected, a major portion of the industry is located in Chicago and the surrounding communities of Cook County. Nearly 48 percent of Illinois' citizens and 47 percent of its elderly population reside in Cook County. However, Cook County's 245 long term care facilities represent only 35 percent of the beds in the state and less than 41 percent of the SNF beds. Facilities tended to be larger in Cook County than downstate (140 beds compared to 92 beds) and more expensive.

As in most states, Medicaid has been the major purchaser of long-term care in Illinois. In fiscal year 1976, state payments to nursing homes amounted to over \$208 million, representing 27 percent of the total Medicaid budget of \$771 million.² Approximately 49,200 Medicaid recipients received care, 11,200 in SNFs, 30,500 in ICFs and 7,400 in sheltered care homes.

Table 1

Long Term Care Facilities and Beds, March, 1977

<u>Level of Care</u>	<u>Downstate</u>	<u>Cook County</u>	<u>Total</u>
SNF: Beds	23,024	15,654	38,678
ICF-I: Beds	28,417	13,530	41,947
ICF-II (Sheltered Care): Beds	10,918	5,186	16,104
Provisional: Beds	891	0	891
Total Beds	63,250	34,370	97,620
Total Facilities	694	245	939
Average Facility Size	91.1	140.3	104.0

Table 2

Facility Size Distribution, March, 1977

<u>Number of Beds</u>	<u>Number of Facilities</u>
0 - 49	238
50 - 99	340
100 - 199	170
150 - 199	82
Over 199	109
Total	939

Table 3

Long Term Care Facilities By Type of Ownership, March, 1977

<u>Type of Ownership</u>	<u>Downstate</u>	<u>Cook County</u>	<u>Total</u>
County	40	0	40
Hospital District	5	0	5
Church Operated or Affiliated	48	31	79
Other Non-Profit	33	15	48
Individual Proprietorship	90	10	100
Partnership	67	30	97
Corporation	326	149	475
Trust	23	3	26
Out of State Corporation	56	2	58
Unknown	6	5	11

Source: Illinois Department of Public Health. Unpublished. Undated.

Data concerning Medicaid's share of total industry revenues are imprecise. Assuming that all Medicaid patients stayed in the homes for a full year, that the private rates were equal to the Medicaid rates (which were, in June, 1977, an average of \$19.77 a day for SNFs and \$15.64 a day for ICFs) and that the home's yearly census equalled Medicaid's 93 percent imputed occupancy rate, then in 1976 Medicaid reimbursed and regulated a maximum of 54 percent of the industry's total revenues. Those assumptions are, of course, mildly heroic. Regardless of the exact percentage, Medicaid's financial involvement in nursing homes is considerable.*

State control extends well beyond the determination of rates. Illinois' regulation of nursing homes is divided among the Department of Public Health (DPH) and the Department of Public Aid (DPA), the Department of Mental Health Developmental Disabilities (DMH), the Health Facilities Planning Board and the Fire Marshal's Office within the Department of Law Enforcement.

DPH is responsible for setting nursing home standards, inspecting homes, certifying ICFs and SNFs and initiating enforcement proceedings. In addition, the DPH Office of Health Finance, a special agency created by Executive Order in 1971, is responsible for "determining the rates at which state agencies and departments purchase health care services (and) collecting, analyzing and disseminating to state agencies and departments such data on health care costs, supply and demand for health service and economic trends as is necessary for rate determination (and)...conducting the functions of negotiations,

* If Medicaid patient length of stay is less than a year, then the 49,200 Medicaid patients represent fewer than 49,200 patient bed years; that is, they fill fewer than 49,200 of the 97,620 beds. If private pay rates exceed Medicaid rates (and both state and industry surveys and studies clearly indicate that they do), then the number of Medicaid patients overrepresents their revenue potential. Finally, if the industry's occupancy level exceeds the imputed 93 percent level, beds assumed to be empty will be filled with private pay patients and Medicaid's revenue share will be overestimated. If the occupancy levels are less than 93 percent, Medicaid would not reimburse its proportionate share of fixed costs and again, Medicaid revenues would be less than 54 percent of the industry's total revenues.

determination, review and evaluation in such a way as to assure that health care services are purchased in the most economical manner consistent with the quality of care and with state and federal statute and legislation."³ The Office of Health Finance has played a central role in the development of the most recent nursing home reimbursement system.

DPA is responsible for determining eligibility of Medicaid recipients, utilization review for ICF patients, auditing nursing homes, processing nursing home claims and reimbursement. DMH directs its energies towards monitoring the long-term care received by those with mental health problems. The Health Facilities Planning Board is primarily concerned with issuing certificates of need for new or expanded long-term care beds or for changes in the existing stock. The Fire Marshal is charged with inspecting homes and certifying their compliance with the federal and state fire and safety standards. In addition, counties often run their own homes and license facilities within their boundaries.

Illinois Medicaid Reimbursement

From 1967 to 1978, Illinois Medicaid reimbursed nursing homes on a "point count" system. This reimbursement mechanism consisted of four components: a base rate, a shelter factor, an add-on, and a point-based patient evaluation.⁴ The base rate was an arbitrarily set minimum payment which varied by licensed level of care and geographic region (Cook County and St. Clair County received slightly higher rates than the rest of the state). The shelter factor was an additional monthly payment made if the nursing home's physical plant met certain specifications--particularly the Life Safety Code requirements. All SNFs, new ICFs and many of the remaining

ICFs received this payment. If a facility had approved rehabilitation, activity and social rehabilitation programs, it received an additional per patient payment (an add-on) for each service it provided. The fourth component was based on evaluation of the individual patient. This evaluation consisted of a caseworker's rating recipients according to a 17 item check-list covering a patient's ability to perform daily living activities as well as a patient's mental status and nursing needs. Each item was ranked according to the level of debilitation and assigned a point value (see Appendix A). The greater the debility, the greater the number of points. The point count ranged from zero to 50. Each point represented a given dollar amount.

In 1977, the only year in which data were available permitting cross state rate comparisons, Illinois' average Medicaid per patient day payment to SNFs was \$19.77 and to ICFs, \$15.64. Illinois' rates were low in comparison to state payments within the rest of the North Central region as well as the nation. Of the 32 states reporting in 1977, 19 paid higher average SNF rates and 24 higher ICF rates.*

Table 4

Average Medicaid Nursing Home Reimbursement Rates,
First Quarter, 1977

	<u>SNF</u>	<u>ICF</u>
Illinois	19.77	15.64
Indiana	25.66	19.05
Kentucky	29.37	15.00
Minnesota	20.26	16.90
Missouri	16.10	14.92
Ohio	20.50	17.50
California	20.17	16.05
New York	37.09	27.03

Source: "Program Rate Update, First Quarter, 1977" Memorandum from Wayne Franklin, CPA, to the American Health Care Association State Executive Directors, April 15, 1977.

* Because the states' rates were unadjusted for differences in wages, the costs of land and building etc., this ranking should not be viewed as absolute measurement of Illinois' relative payment levels.

In March, 1978, Illinois received HEW approval for a new cost-related reimbursement system. This payment methodology grouped costs into three categories: support costs (laundry, dietary, housekeeping, utilities and administrative expenses), nursing costs, and capital costs. Support costs are reimbursed up to the 50th percentile of all SNFs and ICFs within a given geographic region. Facilities with support costs below the 50th percentile retain one half of the difference between their costs and the cost ceiling. Nursing costs are reimbursed by type of facility (SNF, ICF, ICF/Mentally Retarded, SNF/Pediatrics) according to the state's established point count evaluation of the patient's level of debility. Operating costs (support and nursing costs) are also adjusted to reflect changes in the CPI and minimum wage increases. Capital costs are reimbursed by aggregating homes into 25 categories (five geographic regions by five facility age groupings), adjusting those costs if the homes occupancy rate was below 93 percent, and calculating a median capital cost per bed figure. Those homes with capital costs at or below the median receive the median payment. Those above receive the median plus 80 percent of their costs up to 110 percent of the median.

III. The Development of Reimbursement Policy

A. Scandals and Improved State Regulation

In 1967, Illinois adopted its point count reimbursement system. That payment mechanism remained intact for over a decade despite recurring objections by different nursing home associations, task force recommendations, a boycott over rates, and surveys indicating that Medicaid rates frequently did not cover costs. Three factors rendered these forces for change ineffective: periodic and heavily publicized nursing home scandals, generally conservative state fiscal policies, and the flexibility of point count reimbursement.

The first major Medicaid nursing home scandal occurred in 1971, when the Chicago Tribune, aided by the Chicago Better Government Association, had four reporters apply for work as mopboys and nurses' aides in 21 Chicago area nursing homes. After six weeks of fieldwork, the Tribune ran a seven part series in early March, 1971 which revealed instances of patient neglect and abuse, unsanitary physical conditions of the homes, improper use of personnel and ineffective enforcement of regulations.⁵ As the series unfolded, governments at all levels responded. A few of the homes discussed in the Tribune were closed immediately by the Chicago Board of Health.⁶ The Illinois Department of Public Aid (DPA) terminated Medicaid payments to some of the homes.⁷ The Director of the Illinois Department of Public Health (DPH) personally performed surprise inspections.⁸ Mayor Daley ordered an immediate upgrading of nursing home requirements and an increase in facility inspections in Chicago.⁹ The Chicago Board of Health, the Illinois State Legislative Advisory Committee on Public Assistance and the United States Senate Select Committee on Aging convened separate hearings in Chicago on nursing homes.¹⁰ For a short period, those involved accused each other of allowing

the scandal to occur. The state blamed Chicago for inadequate regulation and chastised itself for issuing nursing home licenses on the basis of Chicago Board of Health recommendations alone.¹¹ Chicago blamed the state for overloading nursing homes by dumping thousands of mentally retarded patients into the city's long-term care facilities (as authorized under the Illinois 1969 Copeland Bills which mandated massive "deinstitutionalization" of patients in state mental hospitals).¹² The legislature blamed the nursing home associations for not monitoring the care delivered by their members.¹³ The associations responded by saying that that was not their responsibility. In addition, the director of the Metropolitan Chicago Nursing Home Association charged that the "community gets what it deserves...state government is simply not providing enough money for adequate staffing and care."¹⁴ A representative for the Illinois Association of Homes for the Aging--the non-profit association--further charged that its members could "no longer afford (or find other resources for) providing care for elderly Public Aid recipients for whom they receive payment in an amount substantially less than their actual costs. The remedy is singular--more money."¹⁵

Regardless of the nursing home associations' efforts to link poor quality with insufficient payments, public officials treated the quality of care issue as if it were unrelated to reimbursement. Poor government regulation was perceived as the cause. One reason for this was that the Tribune's exposé suggested that a majority of the homes were operating in gross violation of standards and that this was the result of inadequately staffed, incompetent and/or corrupt public agencies. This view was reinforced by the DPH admission that more than 50 percent of the nursing homes in the state failed to meet

minimum standards.¹⁶ Public officials also blamed the operators and the shortage of beds for the unsatisfactory conditions of some of the homes without directly linking the bed shortage or unsatisfactory conditions to reimbursement. For example, the immediate response of the Commissioner of the Chicago Board of Health to the nursing home scandal was "there are people that should not be in this business but they are and its difficult to keep them out. If you close them down, where are you going to put the people (in the homes). It is not our purpose to close homes down. It's our purpose to care for people."¹⁷ Further, as long as some high quality homes could be found rendering good care for the Medicaid rate, it could be argued that payment was adequate (although without adjusting for the cost of inputs within an area, the percentage of non-Medicaid patients in the home, or the private pay rates in the facility, any comparison of homes is suspect).

The state interpreted reactions to the scandals as a political mandate to regulate the care provided in the homes. Governor Ogilvie responded by appointing a special Deputy Director of DPH to eliminate or upgrade substandard homes.¹⁸ Within a year, the state had developed and implemented a client/provider information system (capable of generating data on nursing homes, e.g., ownership, bed capacity, past violations, etc. and basic data on the location and medical reviews of public patients) which scheduled inspections automatically, informed inspectors what to look for, and processed memos to the homes after the inspections officially informing the facilities of violations and the time they had to correct them.¹⁹ In order to use this information system properly, the state added 43 inspectors to DPA staff. By February, 1972, 62 homes voluntarily closed because they were unable to comply with standards, 13 voluntarily changed to a lower level of care, five had their licenses revoked and 31 had DPA payments withheld until they complied with regulations.²⁰

The state's regulatory effort was substantial but it did not eliminate or discover all questionable behavior in the industry. In March 1972, the Chicago Better Government Association joined with the Chicago Sun Times to expose conditions of patients abuse among mentally retarded patients placed in large sheltered care homes in Chicago's 'uptown' district.²¹

The mentally retarded/sheltered care scandals focused public attention on alleged failures by the state to monitor the care delivered. Once again, the state was forced to justify policies and procedures. Two months later, the Carver Nursing Home in Springfield burned down. Ten of the 41 residents died. The fire produced more public indignation because the Carver home had been charged with providing poor care in 1971 hearings held by the Subcommittee on Long Term Care in Chicago.²²

The bad publicity received by nursing homes may have made discussions with the state about reimbursement impossible. Before the 1971 scandals, the state agreed to a 15 percent increase in the rate. After the Tribune exposé the increase was rescinded.²³ In 1972, the state agreed to a 12 percent increase in base rates but only half of that increase was actually implemented in July 1972, two months after the Carver Nursing Home fire.²⁴

The nursing home industry's bad press also made it a part of the gubernatorial race. During his bid for reelection, Governor Ogilvie made a point of reviewing the success he had had in improving nursing home care. Between January 1972 and October 1972 109 nursing homes were closed down for failure to meet minimum standards.²⁵ From September, 1971 to September, 1972, DPH conducted 3,349 surveys of the state's homes,²⁶ more than three surveys per home. The state found that 96 percent of the homes complied with administration standards, 94 percent with standards for medical and personal

care, 95 percent with nursing standards, 96 percent with food service standards and 94 percent with maintenance and housekeeping standards.²⁷

B. Kickbacks, Sheltered Care Upgraded and Boycott

Although nursing homes were discussed, taxes were the primary issue in the 1972 gubernatorial election. Ogilvie's successor, Daniel Walker, was elected on a platform promising to cut taxes and contain state expenditures.²⁸ His administration became known for its fiscal conservative policies. For example, between 1972 and 1976, the state's total general revenue and common school fund expenditures remained the same in constant dollars.²⁹ Reimbursement for skilled nursing facilities increased \$61 per patient month during the Walker administration, an increase of 50 cents per patient day per year.³⁰ In constant dollars, the base rate for SNFs was lower in 1976 than it was in 1972.

Nursing homes remained a prominent issue throughout the Walker Administration. In 1974, the discovery of provider fraud within Medicaid produced evidence of massive kickback schemes between a small number of nursing home operators and pharmacists. Governor Walker responded by creating a task force, headed by Dr. Joseph Wells, Dean of Loyola University's School of Medicine to examine problems in the Medicaid program. The following problems in nursing home reimbursement were identified:

- 1) Because reimbursement increased with the number of points assigned to a patient (i.e., the patient's level of debility), nursing homes were encouraged to exaggerate the severity of the patient's condition. Proof that claimed services had actually been delivered was nearly impossible to obtain. For example, two points are assigned if a patient requires some individual assistance when eating and eight points are allowed for patients requiring "special and continuous supervision of a licensed nurse."* Unless the state

*See Appendix.

placed an inspector in the home, it would be difficult to prove that these services were continuously provided.

2) Some facilities would accept only patients with point counts above a certain level. This made placement difficult. It also encouraged caseworkers to inflate point counts to facilitate placement.

3) The point system discouraged nursing homes from helping patients to become self-reliant.

4) The point system provided a disincentive for quality care, that is, because homes maximized profits by minimizing costs there was a possibility and incentive to cut costs by lowering the quality of care.³¹

To some extent, these objections were a reiteration of the critique made in 1968 by an ad hoc committee of representatives of major provider associations charged by DPA with developing an alternative payment formula.³² The response to the analysis and recommendations of both the 1968 and 1974 special committees was identical. The point count system was not changed.

Regardless of the status of the point system, nursing home expenditures were being forced up by a change in federal regulations. Prior to 1974, the distinction between ICFs and sheltered care was sufficiently blurred that Illinois was able to receive federal Medicaid funds for both types of facilities. In 1974 federal clarification of the definition of an ICF changed that and threatened the federal funding of sheltered care. Two particular problems arose. First, HEW required that all Medicaid patients residing in an ICF must be receiving medical care. Illinois responded by rewriting its regulations. The state now stipulated the need for medical care existed when patients were incapable of administering their own medication. The attending physician was the only one required to indicate when a patient was in need of medical care. In Spring 1975, all sheltered care patients were re-evaluated and

two-thirds of them--approximately 11,000 patients--were upgraded to ICF care at an additional yearly cost of 13 million dollars, about 5 million dollars more expensive than if the state had disqualified the patients for Medicaid and picked up the entire cost of their care in a sheltered care facility.³³

Reclassifying patients was easier, however, than reclassifying facilities. HEW now required ICFs to meet the Life Safety Code provisions. In order for homes to stay in the program and continue to care for their "upgraded" patients, many facilities made the costly changes required to meet Life Safety Code Standards.³⁴

The upgraded ICF patients increased Medicaid nursing home expenditures, without introducing any new public patients into the system. More than that, the upgrading greatly increased the number of ICF patients thereby making any increases in the base rates more expensive than prior to the reclassification. The state responded to this new financial burden conservatively. In fact, between 1975 and 1976 the rate increases were so small, that the state had effectively placed a freeze on rates. Recognizing that some homes might be severely and adversely affected by the rate freeze, the state established a nursing home hardship board in January 1976. Although the board only operated for six months it allowed 200 homes to appeal for rate increases and awarded 50 homes increases of up to \$50 per patient per month.³⁵

The industry felt that the hardship board was insufficient, that rates had been too low for too long and the state did not seem willing to negotiate substantially higher rates. In October 1976, the executive director of the Illinois Association of Health Care Facilities (the association representing the Chicago based nursing homes) built a coalition of 400 homes from within

his association and the five remaining nursing home associations to force the state to meet their demands.³⁶ The homes refused to admit Medicaid patients until rates were raised. The coalition felt the boycott would become increasingly effective with the onset of cold weather, winter sicknesses, and the rise in the demand for nursing home care. The leader of the boycott said that the average Medicaid rate of \$17.12 a day was "at least five dollars too low."³⁷ "The state is putting nursing homes out of business," the industry charged. "If they (the homes) don't shut their doors now to Medicaid admissions, they're in danger of shutting their doors to everyone."³⁸ It was further claimed that 250 homes had gone out of business because Medicaid rates had not kept pace with inflation and that an additional 300 homes were in danger of closing.³⁹

The boycott came to an abrupt end five weeks later. It was broken by the threat of antitrust action and the commitment by newly elected Governor Thompson to listen to the industry and act to "clean up the Medicaid mess."⁴⁰

C. A Critique of the Boycott Charges

It should be noted that while exaggerated, there was some truth in the industry's claims. First, rates did not appear to keep pace with inflation. Between January, 1972 and March, 1976, the Consumer Price Index increased by 36 percent while SNF and ICF rates in Chicago and downstate increases ranged from 13.1 percent to 18.5 percent.⁴¹ Although rate increases did not match inflation, the flexibility of point count reimbursement often allowed providers to increase their revenues by servicing patients requiring higher levels of care or limiting admissions to patients with higher points. The shift to higher levels of care is an effective method for homes to increase their net revenue if the payment/cost ratio for SNFs is greater than the ratio for ICFs. Between 1972 and 1976 the percentage of Medicaid nursing home patients receiving

SNF care went from 8 percent to 23 percent.⁴² In the high cost Chicago area, the ratio of SNF patients to ICF patients was three times greater than downstate.⁴³ The size of the shift to SNFs and the higher incidence of SNF care in high cost areas suggest that the shift was not due to changes in the condition of the patients but was a way of increasing low reimbursement rates. Further, Chicago had an unexplainably higher average point count per patient than the rest of the state.^{44*} If these unexplained points were unrelated to patient debility, then the classification system may have been used to circumvent low rates.^{**}

Surveys by the industry and the state tended to substantiate the charge that Medicaid rates often did not cover costs. A study of a sample of 67 facilities in 1975 indicated the 45 homes showed average costs which exceeded Medicaid rates from \$.20 to \$13.17 per patient day with a median loss of \$1.76 per patient day. The remaining 22 homes showed that the Medicaid rate exceeded their average costs from \$.20 to \$5.74 per patient day with a median profit of \$1.49. For the entire sample, however, there was average loss of \$.94.⁴⁶

Because private pay patients often subsidize Medicaid patients, the study broke the homes down by percentage of Medicaid patients in the facilities.

* The ability of Chicago nursing home owners to require that new Medicaid patients have a high point count may have been directly related to the relative scarcity of beds in Cook County. As noted above, Cook County had 47 percent of the state's elderly population and only 35 percent of the nursing home beds. In the downstate areas, on the other hand, there may have been sufficient competition for patients that placement officials did not have to guarantee that a patient would have a minimum number of points (or at least a minimum may have been lower) in order to find a home willing to admit a Medicaid client.

** The differences in the point scores and SNF proportions could have been due also to changes in regulations during this period, changes in enforcement or the questionable nature of the data.⁴⁵

Table 5

Per Diem Profit and Loss per Medicaid Patient by Percentage

Medicaid Patients

Percentage Medicaid ^a	0-34%		35-52%		53-69%		70-100%	
	<u>Profit</u>	<u>Loss</u>	<u>Profit</u>	<u>Loss</u>	<u>Profit</u>	<u>Loss</u>	<u>Profit</u>	<u>Loss</u>
Number of facilities	4	9	4	13	6	11	7	7
Average profit or loss	+\$1.03	-\$2.86	+\$1.36	-\$1.42	+\$1.95	-\$2.21	+\$2.30	-\$1.90

^a Average percentage Medicaid patients for all facilities = 53%

Source: Illinois Economic and Fiscal Commission, Medicaid Costs and Controls, December, 1976, p. 94.

As the percentage of Medicaid patients increases, the home's private pay rates must increase or the home must lower its costs. Steadily increasing rates would reduce the home's competitive position in the private market and result in fewer private patients. We would expect, therefore, that homes with a large percentage of Medicaid patients are more likely to operate at or near the Medicaid rates than homes with few Medicaid patients. The study tended to support this hypothesis.

This evidence does not necessarily prove that the Medicaid rate is inadequate. Because the study was based on questionnaires mailed out to a much larger sample, there is reason to suspect self selection among those who returned the questionnaire with those homes incurring the greatest losses having the greatest incentive to respond.* Further, the data did not distinguish

* The Illinois Economic and Fiscal Commission accepted that self selection might have biased the sample results. However, they also felt that the following factors "lead [them] to believe that the questionnaire results are representative."

(1) The questionnaires were not returned to the [state] but to the Illinois Health Care Association; IHCA turned the unopened envelopes over to the [state]. There was no mention that the questionnaires would be used for any purpose other than the development of comparative salary schedules for nonprofessional and nursing staffs.

(2) Because county nursing facilities are reimbursed on a different basis, DPA has audited cost reports from them. The costs reported by facilities returning the questionnaire were quite comparable to the audited costs of the county facilities.

(3) Several studies have shown that nursing costs should be about 33 percent of total costs. It was possible to determine nursing costs directly from the questionnaire and determine what percentage they were of total costs. For the entire sample, it was almost exactly 33 percent. At the very least, then, the reports were internally consistent.

(4) A completely random sample of nursing facility inspection records were drawn from the DPH files. They showed no significant differences from the facilities in the sample in terms of scores on medical reviews, number of complaints, and so forth.⁴⁷

between tax deductions which were not cash expenses (e.g., depreciation) and cash expenses which were not tax deductions (e.g., amortization). It would be possible, for example, to report large losses while experiencing a cash surplus.⁴⁸

Even if the losses were "true" losses, they should be taken in context. Historically, nursing homes have operated in two markets--a public welfare market and a more lucrative private market. As long as Medicaid rates paid for some portion of the homes' fixed costs, proprietary operators would be willing to accept welfare patients. More precisely, as long as Medicaid rates were slightly in excess of the Medicaid patients' share of operating (variable) costs, private pay patients paid for their portion of the operating costs plus all the remaining capital costs and profits, and the home could not solicit an additional private pay patient, then it would pay proprietary homes to accept Medicaid patients. Non-profit homes would have slightly altered incentives and would be more reliant on charitable subsidies.*

The charge during the boycott that 250 homes went out of business because of insufficient Medicaid reimbursement was countered by the Walker Administration's claims that it had forced 253 substandard homes out of the market.⁴⁹ How does one determine whether the Medicaid rates were forcing disinvestment in the industry?

* See pages 32-33.

If the rates were inadequate, if they could not be incorporated into a workable financial strategy with private pay revenues and charitable subsidies, then there should be some evidence of overall decline within the industry. Illinois, however, has witnessed just the opposite. Between 1972 and 1976, the number of facilities dropped from 1,094 to 953, but the number of beds increased by more than a third, from 75,069 beds to 97,589 beds.⁵⁰ The industry has changed rapidly. Facilities were larger than they used to be. More homes provide expensive services in modern fire-resistant structures than was the case in 1972. One of the things that has not changed, however, is that nursing homes are apparently a very good investment and the industry is growing.*

D. The Cost Related System

While the state was coping with the boycott, it was also developing a cost related reimbursement system as required by the 1972 Amendments to the Social Security Act. After consulting with the industry, Illinois submitted a plan to HEW in December, 1976. Four months later, the HEW regional office in Chicago approved the system.⁵² In the same month, an Illinois nursing home reimbursement bill (Senate Bill 1308) was introduced before the 80th General Assembly. S.B. 1308 was an industry bill using the language, principles and methodology developed in a reimbursement proposal by the Illinois Health Care Association (IHCA)—the largest proprietary association in the state.⁵³ For example, both the bill and the IHCA reimbursement

*A representative of the Illinois Health Care Association has argued that growth per se does not indicate that the rates were adequate. F. Lynn May stated that the growth may have been the result of 1) provider response to pre-1972 reimbursement rates and appears during the 1972-1976 period because of the lag between the decision to build and the actual completion of construction, 2) efforts by providers to build prior to enforcement of certificate-of-need requirements (Public Act 78-1156) and/or 3) anticipation of the federally mandated cost related reimbursement system.⁵¹ As a rejoinder, we would still argue that while these factors may have contributed to the growth, the expectation and realization of an adequate return is the prime motive for the growth of proprietary firms.

proposal required that (1) patient services be reimbursed on a more elaborate and exhaustive patient assessment device than the point system, (2) ancillary services such as drugs and restorative therapies be isolated from other service costs such as dietary and housekeeping (in recognition of the fact that not all patients receive ancillary services and the ancillary services have higher management costs associated with them), (3) depreciation on capital be reimbursed on the basis of current value rather than the generally accepted historic cost base and (4) profit be based on a return of the (home's) total investment which the IHCA proposal defined as a variant of the Dupont Return on Investment method (equal to a firm's profit margin times its asset turnover).^{*} In addition, S.B. 1308 also contained a provision prohibiting private pay patients from subsidizing Medicaid patients. Given the existing level of subsidization (\$.94 per day in 1975) this was perhaps one of the more costly provisions of the bill.^{**}

S.B. 1308 was not an inexpensive package. One estimate projected an increase in state nursing home expenditures of \$83 million.⁵⁴ The Illinois legislature was persuaded by a successful lobbying effort by the industry that the increase in expenditures was warranted. Some legislators also believed (incorrectly) that all the provisions of S.B. 1308 were required by federal law and regulation.⁵⁵ As a result, the legislature passed S.B. 1308.

Governor Thompson remained unconvinced that S.B. 1308 was necessary. In October, 1977 he therefore exercised his power of amendatory veto.

* The IHCA suggested return on investment (ROI) method for determining profit played a minor role in the development of the Illinois system. However, IHCA's national organization, the American Health Care Association, has advocated the ROI. A critique of ROI will therefore be presented in the forthcoming overview of this study, "Medicaid and Nursing Homes: Reimbursement Policies and Issues."

** See page 16.

He made the mandatory provisions of the bill optional. The Governor also directed the state to work with provider organizations to develop a new reimbursement system.

During the same time period (September, 1977), HEW's central office raised some questions about the Illinois plan approved in April. The Washington office found the method for determining capital costs unacceptable and felt that the plan was too vague in other areas. The regional office was instructed to request clarification from the state.⁵⁶ Illinois submitted a revised plan in October, 1977 and met with HEW staff to iron out differences. A third plan was submitted in early December, 1977.⁵⁷ Again, HEW denied approval. HEW argued that the plan lacked sufficient specificity with regard to cost finding, audits and definitions of allowable costs. HEW also found fault with the system's adjustment factors for imputed occupancy, inflation and minimum wage increases; the use of the point system for nursing costs, and the use of separate reimbursement methods for state facilities and private facilities.⁵⁸ Illinois was asked to submit a new plan.

A December court decision in favor of the industry added a sense of urgency to gaining federal approval. The industry had brought suit against the state on the grounds that the Illinois point system was not a "reasonably cost related" reimbursement system as required by federal law by July, 1976. The courts agreed with the charges and ordered that if the state could not gain HEW approval by January, 1978, then the first HEW approved plan submitted in April, 1977 should be adopted.⁵⁹ Neither HEW nor the industry were particularly enamored with the April, 1977 plan. Consequently, the state received an extension. In March, 1978, Illinois submitted an amended plan and received HEW approval.

The approved system retained the point system but developed a sophisticated methodology for establishing the dollar value of a point and then applied it only to nursing costs. The remaining operating costs are reimbursed up to the cost ceiling established by the 50th percentile of SNFs and ICFs within a geographic area. Capital costs are determined by disaggregating homes by age and location and reimbursing according to the median group experience within each cell.

The state estimated that the new plan will increase the average per diem rate to SNFs and ICFs from \$17.15 to an estimated \$19.55. The net impact on the state expenditures could be an additional \$20 million for the second half of fiscal 1978,⁶⁰ approximately half of what it would have been had the state adopted the industry's plan (S.B. 1308).

Barring the federal requirements for a cost related reimbursement, the point count payment mechanism would probably have remained unaltered. Point count reimbursement persisted because it produced relatively low rates and yet provided sufficient revenues to the industry to permit an improvement in the quality of care and increase in the number of beds.* Even changes brought about by the federal requirements did not force replacement of the point count system but, rather, its refinement.

* Thomas Walsh, Associate Director of the Office of Health Finance, notes that the state's intent in maintaining the system has been to "pay for high need patients without losing control over reimbursement for low need patients (e.g., as would be the case if we simply set a high ceiling rate)." 61

IV. Economic Analysis

The Illinois reimbursement system establishes a prospective rate for each home independent of the home's actual costs. As such, Illinois has developed a complex, sophisticated variation of the flat rate system. There is a problem with using the term flat rate. As William Pollak has noted, "flat rate is often used to describe a system in which all facilities are paid the same per diem rate. This term, however, is inappropriate for many possible systems in which each home receives a different rate, but one which is independent of its own reported costs." We would agree with Pollak that his designation of "facility independent" rate is more accurate and clear.⁶² Rather than interject his terminology, however, we will use the term "flat rate" but apply Pollak's definition of "facility independent" to it. Thus, the term "flat rate" will mean any rate that is not directly related to each facility's individual costs. We present the simple case of a uniform flat rate first so that we can examine the way it affects individual homes and the industry. Then we will examine the more complex Illinois system, which is basically a composite of multiple flat rates. We will analyze the way in which Illinois' reimbursement modifies the incentives of a uniform flat rate.

A. General Incentives - Uniform Flat Rate

Under a flat rate system, an operator maximizes his profits by minimizing his costs. The greater the difference between a home's costs and the flat rate, the greater the profits or losses. If the flat rate is based on providers' incurred costs, as it is in California, providers in the aggregate can increase future payments by increasing current costs. However, an

individual provider's effect on average costs is so small that in the absence of collusion he has little incentive to increase real costs. In fact, an increase in costs is penalized by a reduction in profit. A cost-based flat rate does create an incentive to increase costs per books, however, if this can be accomplished, through disguising profits as costs, without increasing real costs.

While flat rate reimbursement may prompt cost minimizing behavior in the proprietary home, it may give the appearance that the state is supporting excessive profits in some homes. This is because incremental changes in the rate result in large costs (or savings) and produce major responses by the industry. For example, if an increase in Medicaid beds is required, the state normally must increase the rate. As a result, it will encourage homes to either switch some existing beds from formally higher paying private patients to Medicaid patients and/or it will encourage the addition of new beds to the stock. Regardless of where the increase comes from, the cost to the state as the major purchaser will be in excess of the cost of the additional beds made available to Medicaid. For example, a state may have 1,000 Medicaid beds for which it pays \$20 per bed per day. If the state wishes to expand its supply to 1,100 beds, it must raise its rate to \$22 per day, the estimated cost the state must pay in order to encourage an entrepreneur to build and operate the 1,100th bed. When the state raises its rate to \$22, it pays a \$2 per patient day increase to the 1,000 pre-existing homes. The cost to the state for attracting these 100 beds into the market is $\$2 \times 1000$ plus $\$22 \times 100$ or \$4,200. Thus, in this example, the additional 100 beds effectively cost the state \$42 per day. Further, the increase in

Medicaid rates will most likely bid up the private pay rates, thereby increasing the rate at which private patients deplete their resources and become eligible for Medicaid. Finally, the impact of the new beds will not have a uniform effect on existing facilities because of differences in proximity to the new nursing home, differences in profit/non-profit status, organization and administrative expertise. Some homes will immediately feel the competitive pressure and will incur the costs necessary to maintain their patient census or incur the loss of patient revenues. On the other hand, some homes' costs will be unaffected by the additional beds, and consequently, the rate increase will be a bonus for them.

This discussion of the dynamics of flat rate pricing may shed some light on the recurrent charge that it is intrinsically unfair to set rates at median cost because half the industry will then have costs in excess of that flat rate. From an economic perspective, that political attack on flat rate is overly simplistic. In the absence of barriers to entry, flat rates act as a marginal pricing mechanism. Over the long run they will equal the marginal cost of bringing the last Medicaid bed into production. This does not mean that the state consciously sets the rate with a target number of beds in mind, but that the effect of the flat rate, regardless of how it is set, is to attract investors until the cost of the least efficient bed brought into production equals the flat rate.

Nor do flat rates as a marginal pricing tool mean that owners will immediately increase the size of their homes by one bed for a given increase in the rate. The bed stock is the least flexible component of the nursing

home industry. Investors may be willing to build new homes of only 100 beds or more, for example, or to add onto existing structures in units of 25 beds or more. Further, because of the time lag between the decision to build and the actual completion of the new beds, the response to an increased rate may not be seen until two or three years after that rate increase was first issued. Similarly, because nursing homes are single purpose structures functioning in heavily regulated sectors, an owner may find it difficult to exit immediately from the market (by either shifting the home to another use or selling). Thus the result of an effective decrease in the flat rates on the industry's supply of beds may not become apparent for a year or two after the rate changes. Further, incremental rate changes may be viewed as short term phenomena, insufficient to produce any changes in the industry's bed supply. In this case the industry would adopt a wait and see posture, enjoying short term gains (or absorbing short term losses) and act once the rate changes become perceived as being part of a long term trend.

The decision as to how a firm will allocate its existing beds between Medicaid and non-Medicaid patients is directly linked to the relative revenue potential of both markets. In most instances, the allocative response by the homes could be more rapid than decisions to build or disinvest because the ability to reallocate is constrained only by the availability of unoccupied beds and the rate of patient turnover. Thus the state could experience a more immediate change in the availability of Medicaid beds without any net change in the bed capacity of the industry.

Normally, extremely large profits throughout the industry would be a short run phenomenon which would signal other investors to build nursing

homes, increase competition and reduce excessive profits. (This assumes that in addition to absence of barriers to entry the state actively monitors the financial condition of homes and acts as a prudent buyer: If the state increases rates without regard to actual cost experience, then the state can support excessive profits over time.) On the other hand, average costs which over time are in excess of the flat rates reflect the use of charitable subsidies and the existence of more lucrative private pay patients. Flat rates equal to median cost are unfair only if it is unfair to permit (1) differences in the style of operation between profit and non-profit homes,* (2) differences between the quality of care provided to some private pay patients and level of quality provided to public patients, (3) subsidization of Medicaid patients by private pay patients, and/or (4) intra-state differences in costs between urban and rural communities.

1. Operating Costs A proprietary provider's sole source of profit under a flat rate is the difference between that rate and his average cost. Therefore, to maximize profit he will minimize costs. In terms of variable costs, this means limiting services, staffing levels, salaries, etc., to the lowest level necessary to retain licensure and certification.

What are the implications for quality of care? A definitive answer is impossible in the absence of a generally accepted definition of quality of care. A distinction can be made, however, between quality as defined in terms of the nature and appropriateness of medical services, non-medical services or

*See pages 31-32.

the physical plant.⁶³ Certainly deficiencies in medical care will have a more immediate and undesirable effect than deficiencies in other types of services or goods. Medical care might therefore be considered the keystone to nursing home care. This does not mean that insufficient food or unheated rooms cannot lead to poor health but that beyond a certain point, nutritious meals and properly heated rooms cannot compensate for inadequate medical care. Further, the problem of examining the effect that the flat rate has on each type of quality is compounded by the fact that increased reimbursement does not necessarily lead to an increase in quality and that unconstrained increases in quality of care are not desirable nor necessary. Certainly the state would not wish to forego supporting other public activities (such as education, welfare or non-nursing home Medicaid expenditures), so that it could support whatever level of care the nursing homes decided to provide. Given these constraints and given that the state has a target level of quality (across each of the dimensions mentioned above) greater than that required by licensure and certification, the economic incentives under a flat rate system will be to efficiently maintain the lowest level of quality permitted by law and regulation. Thus the quality of care may be less than targeted, but at or above the level deemed minimally acceptable by the state.*

If there is no competition within the nursing home industry, i.e., if every operator can maintain continuous 100 percent occupancy, there is no incentive to provide higher quality and more extensive services than required by the quality enforcement agency. However, the existence of competition

* Designating care the minimum level of acceptability does not mean that the care is inadequate. It merely indicates the base upon which other services or goods can be added.

will to some extent offset the incentive to minimize quality. First, because fixed costs do not vary with volume, an increase in occupancy results in a spreading of these costs over a larger population, i.e., a reduction in average cost. Therefore, a provider must weigh the cost of increasing quality and scope of services against the potential for increased profits which may be realized if an increase in demand results in lower average total cost (unit cost). This argument becomes somewhat attenuated when placement decisions are placed in the hands of social workers or other third parties who may have more pressing priorities (e.g., rapid placement) than quality.

Second, independent of its effect on occupancy, the proportion of private pay patients in a facility will affect profits. Private pay patients typically pay more than Medicaid pays, demand more than Medicaid requires, and generate greater profits than Medicaid generates. If homes are to attract private patients, they must offer care at a level equal to or higher than other homes competing for those patients.

The strength of these incentives will vary with the level of reimbursement. The higher the payment rates, the greater the likelihood of competition, and thus the stronger the incentive to increase quality in order to attract patients. In other words, as long as entry is unrestricted, increases in the flat rate will attract new beds and theoretically produce quality increase over the long run. In practice, this effect will depend on the geographic dispersion of facilities (i.e., the addition of new beds to the stock in one region of the state will heighten competition for patients within that region), and the array of factors other than the level of reimbursement (access to capital, nursing home scandal, etc.) which influence the decision to enter the nursing home market.

An increase in the level of reimbursement may affect demand as well as supply. If the income eligibility standard for Medicaid nursing home care is related to the Medicaid reimbursement level, a rate hike will serve to expand eligibility. The resulting increase in Medicaid demand will reduce the impact on quality of any supply expansion caused by the rate increase. Again, this effect is subject to geographic variation; in areas in which a significant number of persons have incomes just above the existing reimbursement level, a rate hike will have a much greater impact on demand than in areas where the majority of elderly persons have incomes which place them either below or well above the reimbursement level. Thus, in practice, the extent to which an increase in the flat rate will spur an increase in nursing home quality will vary with location (proximity to new entrants), the strength of other constraints on supply expansion, Medicaid eligibility policy, income distribution within the elderly population, etc.

Flat rate reimbursement also creates incentives with respect to patient admission and care. The system rewards providers for selectively admitting patients for whom they can care at the lowest possible cost, i.e., the "healthiest" (least impaired, least disruptive) patients. In California, for example, spokesmen for the state and the industry identified this incentive as one of the most significant disadvantages of their flat rate system.⁶⁴ California was not only concerned with the hardship imposed on heavy care patients for whom nursing home beds cannot be found, but also with the cost of keeping such patients in hospitals.⁶⁵

Once providers have "creamed" these patients from the pool of persons seeking admission to a facility, the incentive is to care for them as cheaply as possible. While a healthy person will require less nursing care than

one whose functioning is impaired,⁶⁶ the cost of retarding deterioration in patient condition (i.e., providing therapy and restorative services) may exceed the resultant savings on nursing care. Thus to the extent that keeping patients healthy and rehabilitating impaired patients costs the operator more than if he provided routine services only, the payment system encourages him to allow patient conditions to deteriorate.

The discussion so far has concentrated on the disadvantages of flat rate reimbursement; it also has significant advantages over a system in which rates vary with the individual provider's costs. As indicated, flat rates enable the state to retain tighter control over reimbursement expenditures. In addition, they are far easier to administer (thus reducing the state's administrative costs) and allow more accurate budgeting by the state and the provider. And finally, they create a strong incentive to providers to operate efficiently. Cutting back on operating costs does not necessarily result in a reduction in quality. The flat rate system undoubtedly induces operators to seek purchase discounts, eliminate wasteful administrative practices, encourage employee productivity, etc. To the extent that these efficiencies permit operators to spend more generously in areas directly related to patient care, the incentive to operate efficiently may benefit patients as well as the state.

Assuming that the objectives of non-profit providers differ from those of proprietary providers, they can be expected to behave somewhat differently under the system. Proprietary providers seek to maximize profit; the objectives of non-profit providers are less easily identified. The conventional wisdom is that non-profit operations seek to maximize some unknown function of quality and quantity.⁶⁷ For example, a non-profit institution serving

a clearly defined, limited population (e.g., the members of a fraternal organization) may have no desire to expand so long as it can provide sufficient beds to meet demand within that population, and thus its primary objective is to increase quality. Another provider may be willing to sacrifice quality in order to serve as large a population as possible.

From these objectives it follows that a non-profit provider whose patient population is 100 percent Medicaid and who has no other source of income will seek to incur costs at a rate exactly equal to Medicaid's reimbursement. Higher average costs would put him out of business; lower costs would result in a surplus. Because of his non-profit status this surplus could not be distributed, but would have to be put back into the operation thus increasing per patient expenditures to the level of the state's payment.

Few non-profit operations rely solely on Medicaid revenues, however. Most care for some private pay patients and most have charitable contributions and endowments on which they can draw. Under these conditions they can be expected to pursue the targeted levels of quality and quantity as far as their various sources of income will allow. Assuming there is no limit to non-profit providers' desire to expand beds and/or services, they can be expected to spend at rates in excess of the reimbursement level until the pool of charitable contributions allocated for the current period is depleted.

2. Capital Costs Incentives facing a proprietary provider with regard to capital expenditures are the same as those outlined in the preceeding sections: minimize costs subject to the conditions described above. If degree of facility maintenance and restoration, amount of land and square footage per patient can be used as quality measures in the area of capital costs, then providers can be expected to reduce quality, i.e., allow facilities

to deteriorate, build on the smallest tract of land possible and keep square footage to a minimum, except to the extent that this results in lower occupancy and reduced private pay revenues.

A flat rate payment system rewards efficiency with respect to capital expenditures as well as operating cost expenditures. Examples of efficient capital cost behavior which have no negative effect on quality of patient life or care are seeking to obtain the lowest possible mortgage interest rate, accepting competitive bids on facility construction, and substituting labor for certain expensive pieces of equipment. Non-profit providers could be expected to operate efficiently as well; savings could be used to increase quality and size. Again, if efficient capital cost behavior permits operators to spend more generously in areas directly related to patient care, the incentive to operate efficiently may benefit patients as well as the state.

The reimbursement system creates incentives for the financing of capital as well as for real capital investment. The investment decision requires not only the choice of a level of total investment (which determines an owner's assets) but also the apportionment of that investment between the investor's own and borrowed funds (which determines his equity).

Generally, if an owner borrows the money to finance his facility he may claim depreciation and the interest on his mortgage as allowable capital costs. If he invests his own money he may claim only depreciation. The decision to finance rests on a comparison of the mortgage interest rate (i.e., the cost of borrowing) with expected rates of return in other markets (i.e., the cost of investing in the nursing home).

B. The Illinois System

The Illinois reimbursement method carried many of the positive incentives of a flat rate system while offering countervailing rewards to offset some of a flat rate system's disadvantages. It was a system which over the short run should have forced homes to become more efficient and more reliant on non-Medicaid subsidies (from private pay patients, charitable trust, etc.). It also attempted to counteract the incentives for lowering quality and cream skimming. Over the long run, the stringency of the payment system including its failure to reimburse for a return on equity or profit would probably reduce the willingness of homes to participate in Medicaid and encourage disinvestment in the industry.

1. Operating Costs Operating costs consist of support costs and nursing costs. Before rates are calculated, however, reported operating costs were adjusted for occupancy, inflation, changes in the minimum wage and location.

a) If a home's occupancy rate was less than 93 percent (the 1977 median rate for the state) then its occupancy rate was recalculated to equal its actual occupancy rate plus one-third the difference between its actual rate and 93 percent. By making the imputed occupancy rate greater than the actual rate, the state was able to reduce its per patient day costs (i.e., there were now more "patients" to spread costs over). The state claimed that the one-third factor was derived from studies on the impact of occupancy on operating costs. If a home's occupancy was equal to or greater than 93 percent, then its actual rate was used and costs were unadjusted.

From the state's perspective, low occupancy was undesirable unless the state wanted to encourage behavior which also contributed to low occupancy. A variety of factors other than discharges or deaths will result

in empty beds: a relatively small number of elderly within the home's service area (or an excess supply of beds), high private pay rates, poor quality care, and/or mismanagement. In addition, among those homes whose actual occupancy rate was 93 percent or less, the loss of a patient may have had a greater effect on smaller facilities than larger ones. The extent to which this occurs is an empirical question. The desirability of this bias depends upon whether the state wants to encourage smaller facilities. Further, because a statewide median carried with it an incentive for homes with low occupancy rates to seek out patients in areas where the demand for care was greater, the occupancy adjustment encouraged greater allocative efficiency within the industry. Finally, given that the industry is primarily proprietary, there was little reason to suspect that excess variable costs would be incurred as occupancy levels declined. The question was how do per patient variable costs respond to a decline in occupancy. While we should expect a total decline in variable costs, per patient variable costs may also change. If the per patient costs increased, "the State will pay something more than it would have to in an effectively utilized facility...Since we are required to pay only for efficiently operated facilities, there is no reason to assume that (the State) should pay for someone failing to fill his beds."⁶⁸ The problem with the adjustment mechanism selected by the state was that it penalized all homes whose occupancy rates fell below the 93 percent level regardless of whether they took steps to reduce their operating costs. The state had three basic options to remedy this situation. It could have eliminated the occupancy limit but then it would have paid for all increases in average variable costs due to the homes' decline in occupancy. It could have constructed a cap on variable

costs--a per patient amount based on some inputted efficient use of the firms capacity. This in turn raised a series of technical problems (depending upon whether each home has its own cap or is grouped with "similar" homes) which may have been difficult to solve and less equitable than the existing system. Finally, it could have restricted the application of occupancy limits to capital costs and assumed that variable costs would have continued to decline with a decrease in occupancy (and therefore occupancy limits for variable costs were not needed).

b) Because the cost reports used to set the rate were between one and two years old, costs were increased to reflect inflation experienced since the submission of the reports. This was done by comparing the rate of inflation for nursing home costs from the two most recent cost report periods, dividing that by increases in the CPI during the same period. That ratio was multiplied times the projected CPI inflation rate. This adjustment recognized that nursing homes did not purchase the same mix of goods as those used to calculate the CPI.

c) If minimum wage increases occurred, an adjustment in the rates would be made in areas where the shift in the minimum wage was likely to affect the wages nursing homes must pay over and above the increase in costs projected by the inflation adjustment. This adjustment attempted to assist those homes hit hardest by a minimum wage increase, that is, those homes which paid a number of their employees at the minimum wage and would be forced to increase their wages with changes in the law. As an example of how this would work, the regulations discussed the January 1, 1978 minimum wage increase to \$2.65.

The specific adjustment for this change is calculated by dividing the difference between the regional average nurses aid salary updated for inflation as above, and \$2.75--ten cents more than minimum wage--by the updated minimum salary:

$$\frac{\$2.75 - (\text{Updated Regional Average Nurses Aid Salary})}{(\text{Updated Regional Average Nurses Aid Salary})}$$

While the updated regional average nurses aide salary exceeds \$2.75 per hour, no minimum wage adjustment is made. The resulting percentage is multiplied by the estimated amount of total expenses due to non-administrative salary, based on the state's cost reports. The total expenses of each facility within the HSA are increased by that factor.

The industry objected to this adjustment on the grounds that minimum wage increases had "a ripple effect on all wages." Those facilities in areas such as Chicago where the lowest paying job paid more than \$2.75 an hour would nonetheless be affected by the minimum wage increase but would not be reimbursed by the state.

One response to this argument was that homes with wages below the new minimum wage must increase their rates immediately and therefore should be compensated immediately. Although other homes will undoubtedly feel some of the impact of minimum wage inceases, that impact will probably take place much less rapidly and will surface in the cost reports used to calculate Medicaid rates. The rate at which homes must adjust to the minimum wage was the critical factor. The slower the rate, the less urgent the need to isolate wage increase from general inflationary trends within nursing homes.

A representative of the Department of Health also noted that:

In addition, while the ripple of minimum wage is required by management considerations within a facility there is no evidence that it continues to the general wage scale in a community. Some have argued that minimum wage reduces the number of jobs available, so that the surplus labor pool willing to work at the minimum wage may actually expand, making it easier for facilities in the region to hire at minimum wage.⁶⁹

d) Facilities' costs were clustered by health service area. (There are eleven HSAs in Illinois.) This grouping acknowledged differences in costs of inputs between regions and minimized regional advantages. After these adjustments were made, the operating costs were divided into support costs and nursing costs.

2. Support Costs Support costs included laundry, dietary, housekeeping, utilities and administrative expenses. They were reimbursed at actual cost up to the 50th percentile of all SNFs and ICFs facilities (except state MR facilities) in an HSA including those homes with no Medicaid patients. Facilities with support costs less than the 50th percentile would be reimbursed their costs plus one half the difference between their costs and the group ceiling.

The groupings of all SNFs and ICFs for support costs was justified on the basis that all facilities must provide these services and therefore support costs should not vary by level of care. Given, however, that private rates were on average higher than Medicaid rates and that the quality of care delivered to non-Medicaid patients was generally higher than that delivered to Medicaid patients,⁷⁰ we would expect that homes catering exclusively to non-Medicaid patients would have had higher support costs than homes servicing primarily Medicaid patients. Thus by including the few facilities which did not have Medicaid patients in the ranking for support costs, the state probably shifted the median cost ceiling upward. By excluding the few expensive state facilities for the mentally retarded (MR), however, the state probably shifted the median down. The extent to which all this affected the median is, of course, an empirical question.

Reimbursement for support costs carries with it the flat rate incentive for proprietary firms to maximize profits by minimizing costs. This incentive was attenuated somewhat because nursing homes operating below the ceiling received half the difference between their actual costs and the median. The incentive, however, to minimize costs remained. Its effect would be a function of how minimizing support costs affected quality and how quality in turn affected the home's ability to attract patients, particularly private pay patients. We would also expect that non-profits would spend to the ceiling--if they were not already over the median cost limit. If proprietary homes attempted to remain under the ceiling and if non-profits incurred costs equal to or greater than the median costs, over time we would expect most of the non-profits to be at or above the median cost.

3. Nursing Costs⁷¹ Nursing costs were reimbursed separately for each of four facility classifications: SNFs and ICFS, ICF-MR, SNF-Pediatrics, and state-run MR facilities. We shall restrict our attention to the SNFs and ICFs grouping because it had by far the greatest number of homes within it and the reimbursement technique applied was the most interesting of the four classifications.

The calculation of nursing costs attempted to address the differences in costs incurred by homes because of differences in their patients' conditions. It attempted to recognize the cost of acceptable quality care. Finally, it attempted to reverse the general incentive under a flat rate system for cream skimming the healthy patients. In order to do this, the state constructed a cost function for nursing costs; that is factors which were likely to affect nursing costs were identified (e.g., wages, patient debility, quality of care, etc.) and the usefulness of the cost function was then statistically tested by collecting cost data from the homes and regressing the independent

variables (the factors thought to affect nursing cost) on nursing costs. As a statistical tool, regression analysis tests the impact that each factor has on nursing cost independent of all other factors. For example, if nursing costs were thought to be a function of quality of care, profit/non-profit status of the homes and patient mix, then regression analysis would examine how nursing costs change when quality of care changes but when ownership status and patient mix remain constant; how nursing costs change when ownership status changes but when quality of care and patient mix remain constant, and so on.

The Illinois system identified non-labor inputs, wages, certification level of the homes, the patient point count, a quality score, ownership (county, voluntary, profit) and the proportion of Medicaid in the homes as the factors likely to affect nursing costs. All but two of these factors were included in the regression. The cost of non-labor inputs were not included because they were assumed to be uniform throughout the state. Because of the size of the sample, a wage-salary deflator calculated from nursing cost reports was used to adjust the regression's estimates for differences in regional labor costs.

The regression equation explained 60 percent of the observed variance in nursing costs. The equation was then "condensed into an administratively feasible formula" for the purposes of actual reimbursement. This was done by fixing the values of some of the variables to establish a base rate reflecting state preferences for a model home; for example the high coefficients of county and voluntary homes which indicated that these facilities were more expensive than proprietary homes were disregarded on the grounds that "there is no compelling reason to believe that the state shares the objective

functions of either of these groups nor to assume that the state should share in any inefficiencies which the higher costs represent."⁷² Although initially it was argued that the proportion of Medicaid patients should be assumed to be 1.0 because "the state has no preference for providing a level of amenities unrelated to patient care which is in excess of that required to attract Medicaid patients," the actual proportion of Medicaid patients (53 percent in 1978) was used in the equation. Finally, the quality index (a composite of ratings gleaned from licensing inspections, medical reviews and private complaints and tested against the evaluation of state caseworkers and inspectors) was set equal to a hypothetical rating which indicated that good care was being provided. All of these factors were estimated as constants and added to the constant term in the equation. The condensed equation then assumed the following form

$$R = \text{Constant} + A_1 \times P_1 + A_2 \times P_2 + A_3 \times S.$$

Where R = reimbursement for nursing care
 P_1 = number of points through 17
 P_2 = number of points over 17
 S = one for a skilled bed, and 0 for all other circumstances.

As noted in the regulations:

The multiple regression equation indicates that a reasonable estimate of increase in the daily cost of care for 1978 would be \$.24 per point up to 17 points. Above 17 points, each additional point would be expected to add \$.20 per day to cost. The regression also indicates that a reasonable estimate of the cost of providing a day of skilled care is \$1.88 above the cost of a day of intermediate care. The resulting reimbursement equation is:

$$R = \$2.93 + \$.24P_1 + \$.20P_2 + \$1.88S.$$

To illustrate how the reimbursement equation would be applied, consider a patient who is assigned 20 points by a Department of Public Aid caseworker upon entering a facility. Care would be reimbursed at:

\$2.93	base rate
4.08	first 17 points
.60	points from 18-20
<u>\$7.61</u>	

If, in addition, the patient had a condition which required skilled nursing care and occupied a skilled bed, reimbursement would be increased an additional \$1.88.

If the subject facility is in an area where the cost deflator equals 1.0, \$7.61 for an intermediate patient or \$9.49 for a skilled patient in a skilled bed would be the rate to be paid. If the deflator for the area was .9, for example, the rate would be multiplied by .9 to obtain the reimbursable rate--\$6.85 in the case of the intermediate patient.

It is worth pointing out that since all patients have some points, the actual minimum payment is larger than the base rate alone. For instance, 7 points is a very low point count for an ICF patient. This would, however, create a program reimbursement of \$4.61. Likewise, the usual cut off between SNF and ICF is 25 points so an average minimum SNF nursing reimbursement would be \$10.49.⁷³

This approach to reimbursing nursing costs had several advantages. It recognized differences in patient disability, thereby attempting to counter the incentive present in the support components of the reimbursement system to cream-skin the healthiest patients. It focused on a cost most likely to affect the quality of care received. And, it derived the cost estimate in a two step process which carefully sets forth pertinent variables and a reasonable state policy towards those variables.

There were problems, however. Forty percent of the variance remains unexplained by the equation. This was due either to random fluctuations or a failure to capture critical variables. (Although, it should be noted that a regression equation as simple as the one employed, which explained 60

percent of the costs, offers a relatively good fit for cross sectional data.) If unexplained variance was due to the omission of a critical variable then some concern should be voiced as to how this tended to reward or penalize homes and whether those sanctions were consistent with public policy. If the unexplained variance was due to random fluctuations, however, then the coefficients would be unaffected. The variance would be evenly distributed around the estimates thereby not introducing any systematic rewards or penalties. And the method for establishing reimbursement would be more flexible and explicit and therefore more fair than if costs were simply paid up to a given percentile of nursing home costs.

Nor does this technique eliminate the weaknesses of the point system itself. The industry objective to the continued use of the point count because

the bulk of nursing and program costs are required (sic) by minimum standards and are not affected by patient point count...a statistical model based upon cost reports will not reflect staffing costs necessary to provide quality care (because)...actual staffing costs reported on the cost reports are artificially low, (the result) of years of reimbursement at below costs. (Finally), although staffing patterns are not required by law, the state has the capacity to develop guidelines for minimum staffing requirements to meet existing regulations.⁷⁴

The industry's objections were inconsistent. On the one hand, they argued that minimum standards dictated most of the nursing and program costs and not the point count. If that were true, then the minimum standards were either high enough to meet the needs of patients with the highest possible number of points or some patients were not receiving the care they needed. In either case, the point count should have registered as an insignificant variable in the regression equation. This did not occur.

In fact, the equation revealed just the opposite, i.e., the point count was an "important and statistically significant predictor of operating cost." Further, it was difficult to argue that minimum standards dictated costs and then argue that there were no quantitative standards (i.e., staffing patterns). Thus, while the state demanded that certain types of personnel be in the homes, it only required that the staff be sufficient to perform the tasks at hand rather than specify specific staff to patient ratios. Without minimum staffing patterns, the industry could not argue that state standards were responsible for most costs.

The industry's most substantive charge was that costs were artificially low because of the reimbursement system and therefore it was improper to use current nursing home costs as a basis for future payment. In the old system, base rates were arbitrarily assigned. Although the points rose with the expected increase in care that was associated with an increase in debility, the points were not carefully related to the costs of providing a given service. For over ten years, however, the industry had survived and expanded because of its ability to use the point system. Thus, the regression was more likely to pick up the industry's response to the previous reimbursement system rather than the reliability of the point system as an independent indicator of patient related costs. Distortions and problems with the point system may have produced distortions and problems within the industry. The costs, however, could have been artificially high in light of the incentive to admit patients whose characteristics produce a point count that was the least expensive to care for relative to all other ways of arriving at that given point count.

Thomas Walsh, Associate Director of the Office of Health Finance, discounted either effect noting that while the point count system posed a constraint, concern with that constraint was irrelevant because

- a) County, voluntary, and homes which cater to the 40-50 percent of the market which are private payors were not constrained by state policies and our sample includes this entire range of cost and reimbursement experience.
- b) We use this experience to estimate a relationship, and reimburse according to that relationship. Even if 70 percent of the facilities were reimbursed too little to permit adequate care in the past, if we accurately estimate the relationship and reimburse at a level which permits good quality, the past under-reimbursement is irrelevant.⁷⁵

There were more basic problems with the point system other than its effect on historic costs. In a critique prepared by Thomas Walsh and Mike Koetting (also of the DPH Office of Health Finance), they argued that a patient assessment tool such as the point system had four problems:

1) It was administratively complex and costly. It required that patients be frequently reevaluated at a cost in Illinois of \$4 million a year.

2) Discretion on the part of caseworkers produced discrepancy in patient classification. It was open to individual shortcomings of caseworkers to inconsistency in the application of point count standards, to arbitrary or capricious disregard of those standards and to bribery by nursing home owners to increase points. In addition, there was a systemic and unexplainable difference of 15 percent between the average point scores between regions within the states.* If the measurement error is systematically related to variations in cost, then the estimating coefficients will be biased and specifically the coefficients related to the points will be biased toward

* As we noted earlier, this could have been due to, in part, differences in the bed supply. See p. 16.

zero. (In plain language, the coefficients become unreliable.) The state remedied this problem by establishing a monitoring system which flagged caseworkers, offices and regions which deviated from expected point count patterns. Perhaps just bringing the problem to the attention of DPH was sufficient. Because of these actions and greater reliability of current data, interregional differences in the point count no longer existed in 1978.

3) Simple patient assessment techniques like the point count system "cannot capture all of the needs which can be expected to affect costs of operation. In this case, those patients whose needs are not well represented will have difficulty finding placement. The solution to this objection is obviously to expand the assessment tool. However, the more complex the tool, the greater the administrative expense and possibly the greater the degree of judgment required by caseworkers in evaluating patients."

4) There are questions as to how consistent the relationship of points are to each other in the assignment of levels of disability and the costs associated with those disabilities. If feeding a bedridden patient costs \$2.00, but the points for that level of disability produces revenue of \$2.50 a day, then the incentive is to keep the patient in bed. On the other hand, if a patient requiring daily colostomy irrigation costs \$6.00 a day but produces revenue of \$5.00 a day, then the incentive is to not accept patients with those needs or provide the service less frequently than is necessary. Thus, if the cost for performing a given service deviates from the revenue generated by the points, then the system will tend to either reward homes for keeping patients sick rather than curing them or deny patients necessary services because of insufficient payment.

It was not clear how strong the cumulative incentive to let a patient deteriorate was under the point count system nor how that general incentive might be thwarted by assigning different points to levels of disability. Nor was the level of "preference" for certain disabilities clearly understood. If the points were seriously out of line, then they might have biased nursing home behavior in a direction inconsistent with public policy.⁷⁶

The assumption, however, that the point count system necessarily provided a disincentive for improving patient condition was not supported by empirical studies and must be examined carefully. As Walsh properly observed:

The fact that some amount is being paid to care for specific conditions does not imply an incentive to either cure or retard progress. Only if payment less cost in the debilitated state is greater than payment less cost in the well state can an incentive be said to exist.

[In addition,] a disincentive may exist in any system which does not have an effective quality incentive. The factors which contribute to quality--getting staff to talk to and take an interest in patients, perform unpleasant tasks, use the proper procedures in treating patients, etc.--require performance of difficult management tasks. While it is relatively easy to increase costs, there is no assurance that those increases will result in better patient care. (A case in point is State institutions, where we have had enormous staffs for years, but complaints regarding care provided have led to a major deinstitutionalization movement.) Unless an attempt is made to explicitly measure quality and reward for its provision, there is no guarantee that management will be adequate, or will even receive reliable feedback regarding its inadequacies. In fact, the more lenient the reimbursement system, after the point where sufficient resources are provided, the greater the temptation to throw more resources at a problem and neglect fundamental management solutions. The point count system makes it more difficult to throw resources at a problem in facilities which provide care to patients with low care needs, and consequently draws attention to the quality issue. It is not clear, however, that the resulting care will be poorer than would be provided under an alternative system.

[Finally,] despite all the discussion, no one has ever produced evidence that an effective disincentive to quality care exists. The criticism has appeal because it addresses "quality" with which elicits a pavlovian response from a number of quarters. There is, for example, no evidence that Illinois patients are more debilitated or less often rehabilitated than patients of other states.⁷⁷

In terms of the relative merits of the point system one must accept that reimbursement systems alone do not and cannot guarantee that an acceptable level of care would be provided or that all patients regardless of their condition would be accepted into a home. To use a well worn phrase, adequate reimbursement is a necessary but insufficient condition for assuring acceptable care or access. All that can be expected is that reimbursement be structured in such a way that it complements other regulatory devices designed specifically to monitor and control quality and access. In view of this complementary objective, the point count system must be judged relative to other current options. The state, for example, could have used other patient assessment tools, linked reimbursement to the quality of the home (as measured by inputs and/or procedures) rather than the conditions of the patient or refrained from incorporating either type of mechanism into the payment system. Of the three options, only patient assessment permitted the state to "tailor reimbursement" to the disability of the patients. This had been, and continues to be, an important state objective. To the extent that a patient assessment device accurately discriminated between levels of patient disability and reimbursed accordingly, it overcame two of the major objections to rates set independently of each facility's experience: it eliminated the economic incentive to cream-skin healthy patients and dampened incentives to lower quality below acceptable levels.⁷⁸

The states continued use of the point count system was based on its unsatisfactory experience with other patient assessment instruments (most notably PACE) and its belief that weaknesses in the point system, particularly in terms of "objectivity and completeness can be remedied by redesign." That redesign is currently underway.

4. Capital Costs Capital costs include depreciation, interest expenses, and property taxes. These costs were grouped by five age of investment classifications and five geographic regions. The age of investment was used to adjust for differences in the financial markets over time. The geographic regions attempted to adjust for differences in the cost of inputs within a given time period.

For the initial year of the system (1978), the latest acquisition of an existing home prior to July 1, 1977 served as a basis for the grouping. The date of construction was not used because data on original construction were generally unavailable. July 1, 1977 was used as an arbitrary cut off because of a surge of financial transactions (sales, leases, etc.) which inflated costs in anticipation of a cost related reimbursement system. Homes constructed after July 1, 1977 might be placed in different categories if "cost data indicates that such groupings are appropriate."

Once a home was classified, its grouping was not changed because of sale, refinancing, leases, etc. However, all new construction, renovation, or investment in capital was classified by date of purchase. Capital costs were adjusted for an imputed 93 percent occupancy rate or actual occupancy level, whichever was higher. Only straight line depreciation was allowed. An asset may be depreciated only once. If there was a change in ownership, only the useful life unclaimed by previous owners was recognized.

Once the capital costs per patient day were derived and disaggregated by joint age and location classifications, the median capital costs for each cell were calculated. Homes with capital costs at or below the median received the median. Those with costs in excess of the median would receive 80 percent of that excess up to 110 percent of the median. Capital costs in excess of 110 percent of the median would not be reimbursed.

Group medians were to be recalculated annually. However, as a means of containing costs, group rates would not be allowed to increase over 1978 costs by more than 125 percent of the change in the CPI over the 1978 CPI. This constraint was not placed on rate increases due to renovation or new construction.

For the individual home, this form of capital reimbursement had clear incentives. If the home had capital expenditures less than the median, it received a bonus. If costs were equal to the median, it met its costs. In either case, if all other costs were being met, the incentive was to stay in the program or expand participation in Medicaid. It should be noted that because there was no return on equity, there was a strong incentive for any owner with capital costs below the median to withdraw whatever equity he might have in the home (by refinancing his home up to the capital limit) and reinvesting that money in a more profitable venture. If the home's capital costs exceeded the median, it received a penalty which increased substantially for costs in excess of 110 percent of the median. The incentive was to minimize losses by either refinancing or altering the composition of the home's patient census. Refinancing was desirable if current mortgage terms were better than the terms under which the existing mortgage was issued or, if by increasing the percentage of capital costs apportioned to interest expenses (and thereby decreasing the percentage apportioned to amortization), the tax savings exceeded the losses incurred under the Medicaid capital reimbursement. The latter might be advantageous if refinancing would result in non-reimbursable interest expenses and amortization costs in excess of depreciation were less than those expenses under the existing mortgage. The home could also minimize the effect of the cap by altering its patient composition and increasing the proportion of non-Medicaid patients. This

could be done by actively recruiting private patients, refusing to accept new Medicaid patients or dropping out of the Medicaid program altogether. The intensity of the response is a function of total losses on a Medicaid patient (and not merely losses on the capital component of the reimbursement system) and the existing level of private pay and/or charitable trust subsidies. It should be noted, that if total losses persist after refinancing and shifts in patient composition, the incentive is to cut back on the more flexible operating costs; that is, insufficient capital reimbursement may cause a decline in quality of care.

The fixed historical base and useful life of a home should have two effects: it should eliminate any incentive for trafficking (the selling and reselling of property at inflated prices) and it should affect older facilities in less favorable fashion than newer ones. The latter would occur because sales prices (which must be reasonable^{*} in order to be reimbursed) may not keep up with inflation and median capital payments would continue to decline in real dollars over time. The net effect might be rapid disinvestment of older homes well before they reach the end of their 40-year useful lives.^{**}

Any additional impact of this form of capital cost reimbursement on the industry depended on how widely dispersed capital costs were around the median. It was quite possible that the costs for all the homes fell within 10 percent of the median amount. If there was a wide dispersion around the median, however, it is possible to speculate about what types of homes would be most

* An unreasonable cost would be one which exceeded 110 percent of the median costs.

** Disinvestment here refers to a non-public owner removing his home from the non-public sector by abandoning it (which in some states places the home in public receivership) or by modifying or selling the home and the land it is on for non-nursing home purposes.

affected by the reimbursement system by examining two major factors which would affect capital costs and which were not adjusted for by the payment mechanism. They are: (1) the cost of purchasing the capital (mortgages, refinancing arrangements, etc.) and (2) the physical quality and size of the home and the location and size of the land.

Mortgage payments are a function of the principal borrowed, the interest rate agreed upon and the length of the mortgage. For any given loan, if the interest rate is increased or the length of the mortgage shortened, then the payments required to amortize the loan are increased. Similarly, if the interest rate is reduced or the length of the mortgage increased, the mortgage payments are reduced.

Within any of the age/location categories, then, those homes with mortgage or refinancing terms which had relatively lower interest rates or longer maturation periods would also have lower per capita costs. This should favorably assist in positioning them relative to other homes. Those homes who had comparatively poor financial arrangements may find themselves well above the median.

It was not unreasonable for the state to expect homes to negotiate the least expensive mortgage possible. Nor was it unreasonable to assume that within given time periods, homes should have received financing under similar conditions. Reimbursement up to 110 percent of the median costs implicitly suggested these expectations. The system, however, also suggested a bias against homes whose physical plant and land exceeded licensing and certification requirements and thus cost more than homes which used the same quality inputs but which were built to meet only the minimum standards.

While this appeared to be a straightforward relationship the market apparently behaved differently than expected; that is, the state had been unable to discern any significant relationship between bed size or square feet per bed and capital costs.⁷⁹

Finally, while we may discuss the intricacies of individual components of the reimbursement system, the final decision as to whether a home was maintained or sold did not rest with an isolated part of the capital cost reimbursement methodology nor for that matter with capital cost reimbursement alone, but with total reimbursement. If total reimbursement was sufficient to meet costs plus provide an adequate rate of return, then the industry would grow.

5. The Impact on the Industry One difficulty in analyzing the Illinois system is our lack of information on the adequacy of the point system; for example, we do not know what percentage of the homes had all their nursing costs covered by the point system, what percentage of total nursing home beds did those homes represent, what was the quality of those homes as measured by the state's quality index and so forth. If we assume, however, that the nursing cost component covered costs, then we can analyze the impact that remaining components of the system will probably have on the industry.

It should be noted that Illinois did not explicitly recognize profit or a return on equity and that the nursing cost component represented 25-30 percent of the home's total costs exclusive of a return on equity.⁸⁰ The remaining 70-75 percent of costs (support and capital costs) were reimbursed up to median cost ceilings. Setting the rate at the median is, by definition, setting the rate so that half of the facilities in the class have incurred costs above the rate and half below. This is a slight oversimplification,

however, which ignores the cost of capital--an economic cost for any investor. A proprietary provider whose entire census is Medicaid will incur economic costs in excess of the rate unless the rate is equal to or greater than the sum of his operating cost, capital costs and a reasonable rate of return on his equity (i.e., the rate of return in another market of comparable risk). In other words, all non-profit providers with total allowable costs greater than the rate and all proprietary providers with total allowable average costs greater than the rate less a reasonable return on equity will operate at a loss on each Medicaid patient.

As the earlier discussion of flat rates as marginal cost pricing mechanisms demonstrated, this was not necessarily unreasonable in an industry in which subsidies (from private pay patients and from charity) have always been prevalent.* It does follow, however, that every provider who was consistently above the breakeven point must rely on one or both kinds of subsidies to survive. In other words, under prolonged flat rate median cost reimbursement, all facilities above the median must be non-profit operations with charitable funds or have private pay populations sufficiently large to cover the deficit incurred in caring for Medicaid patients.

The relative proportions of public and private pay patients necessary to keep revenues in excess of costs is a function of the relationship between average total cost and the private pay rate. Clearly, if a provider relied

* The term subsidies is used to indicate a situation where private pay rates are higher than Medicaid rates and where those higher rates are used to cover fixed costs and profits not covered by Medicaid rates. Unfortunately, "subsidy" implies that the state could adopt a pricing policy for its Medicaid patients which would eliminate the disparity between private and public rates. This would occur only under very special conditions. For discussion of this issue, see B. Spitz and J. Weeks, "Medicaid Nursing Home Reimbursement in Minnesota," Urban Institute Working Paper 5905-5.

solely on Medicaid and if his cost exceeds the Medicaid rate, he will not participate in the program. If he has both Medicaid and private pay patients and if his average total cost is met or exceeded by the Medicaid rate, subsidy by private pay patients will be unnecessary. (This does not mean private rates will necessarily be lower.) But, if the Medicaid rate is greater than average total cost, he can still operate at a profit if the private pay patients cover a disproportionate amount of the total fixed costs. In other words, a home will be able to earn a profit if the excess of the private pay rate over average total cost times the number of private pay patient days exceeds the excess of average total cost over the Medicaid rate times the number of Medicaid patient days.

$$PP(R_1 - ATC) > MC(ATC - R_2)$$

PP: number of private pay patient days

MC: number of Medicaid patient days

R_1 : private pay rate

R_2 : Medicaid rate

ATC: average total cost

Those facilities in the upper half of the cost array which are unable to secure sufficient revenues from non-Medicaid sources will be forced to leave the market. With each firm that leaves the market, the median will shift down; e.g., if ten firms in the upper half of the array leave the market, the median will shift down until five firms which had previously fallen below the median, move above the median. This process will continue until the industry reaches an equilibrium in which at least half the firms are either non-profit operations willing to subsidize Medicaid patients with charitable funds and private pay patient revenues; proprietary operations with a sufficient number of higher paying private pay patients to subsidize Medicaid patients; or, homes which do not accept Medicaid patients.

Of course, the industry may move toward this equilibrium from below as well as above. If private pay demand is sufficiently strong to support high profit margins throughout the array (below as well as above the median), new firms can be expected to enter the market (assuming no barriers to entry) until the equilibrium described above is reached. It bears repeating that in this equilibrium state, all the firms would be earning total revenues equal to or in excess of costs despite a Medicaid rate which is lower than the average total costs of at least half the facilities in the state.

The existence of the equilibrium state depends on an annual inflation adjustment equal to actual inflation. If that adjustment fails to keep pace with increases in input costs, the median will drop (in constant dollars) every year until only a small number of firms remains in the Medicaid program, assuming that there is some floor below which an operator cannot reduce average total costs. The existence of quality standards assures that there is such a floor. If, on the other hand, the adjustment is greater than actual inflation, then the median will rise and increase the number of firms participating in Medicaid.

Whether the state considers it desirable to continue to set rates at the median depends on the freedom of access to Medicaid beds it wishes to ensure. The industry has been growing since the inception of Medicaid. One state official felt the state was overbedded. If there was an excess supply then we would expect that the current system would reduce the number of Medicaid beds. When the supply reaches the level the state considers adequate, it should simply hold the rate constant (in constant dollars).

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APPENDIX

Illinois Cost Related Reimbursement
For Skilled Nursing and Intermediate Care
Facility Services

Approved by DHEW: March 30, 1978

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled Nursing and Intermediate Care Facilities

I. Cost Finding

- A. Cost reports reflecting costs on the basis of generally accepted accounting principles, will be submitted for each facility at least annually.
- B. Reports will be submitted on uniform cost reporting forms developed jointly by the Illinois Departments of Public Health and Public Aid. A set of the cost report forms and instructions is appended. (See pages 15 through 56 of the Appendix.)

C. Reporting Periods.

- 1. For facilities having fiscal years ending February 1976, through August 1976, the initial report will cover either the period September 1, 1976, through January 31, 1977, or the facilities' most recently completed fiscal year.

For facilities having fiscal years ending September 1976, through January 1977, the initial report will cover the most recently completed fiscal year.

- 2. Subsequent reports will cover the facilities' fiscal year or other period agreed to by the Departments of Public Health and Public Aid at the facilities' request.
- D. Initial reports are to be submitted by March 15, 1977. Subsequent reports are due within 90 days after the close of the reporting period.
- E. All facilities are required to complete the cost reports using the accrual method of accounting. Exceptions may be made for governmental institutions operated on a cash method of accounting.
- F. Facilities are required to retain sufficient records to support and verify the cost reports for a minimum of three years following submission of the cost report, and to make such information available to both State and Federal staff upon request.
- G. The Department of Public Health will retain all cost reports for a minimum of three years after receipt.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related Reimbursement to Skilled Nursing and Intermediate Care Facilities

II. Allowable Costs

- A. Allowable costs include reasonable costs of meeting licensure and certification requirements including the provision of services required by licensing standards. Allowable costs shall include the reasonable cost of all items of expense which providers incur in the provision of routine services.
- B. Other items as indicated by the Department of Public Aid may be identified as non-allowable, but shall not include any item specified in A. of this section.
- C. All related organizations doing business with the facility, and the specific transactions, must be identified on the cost report. Allowable costs of purchases of any item or service from a related organization are restricted to the costs allowed by Medicare guidelines as specified in the Health Insurance Manual 15.
- D. Costs not related to patient care, as well as costs in excess of those required for the efficient and economical delivery of care, will be disallowed. Examples of non-allowable costs are:
 1. Any service not related to direct nursing care such as day care, other out-patient care, non-patient meals, and non-patient laundry.
 2. Any revenue producing amenities such as the gift and coffee shop, barber and beauty shop, and television and radio in the resident's room.
 3. Any services which the Department pays for separately such as laboratory, radiology, and dental services.
 4. Cost of items sold to patients or non-patients and the cost of any non-group care restricted drugs.
 5. Any expenses incurred by the owner or owning corporation which are not nursing care related. Such expenses would include the following:
 - a. Non-working officer's salary
 - b. Compensation to non-working owners
 - c. Non-care related interest

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled Nursing and Intermediate Care Facilities

- d. Non-care related owners' transactions
 - e. Personal expenses of owner
 - f. Non-care related fees
 - g. Training program for non-employees
 - h. Fines and penalties
 - i. Entertainment
 - j. Contributions
 - k. Owner or key-man life insurance
 - l. Special legal fees
 - m. Non-care related patient transportation
 - n. Malpractice insurance for individuals
 - o. Non-patient related transportation and travel
 - p. Bad debts
- 6. Owners compensation in excess of compensation in comparable situations.
 - 7. Non-straight line depreciation or depreciation in excess of Medicare guidelines.
 - 8. Unnecessary interest expense as determined by HIM-15 guidelines.
 - 9. Expenses incurred in transactions with related organizations above the cost of the organization providing those services as specified in HIM-15.
 - 10. In determining allowable costs, no interest cost shall be recognized to the extent that it exceeds payment based on 125% of the prevailing mortgage rate at the time of the loan.
- E. Bad debts of non-Title XIX Program patients, and charity and courtesy allowances, will not be included in allowable costs.

III. Rate Determination

A. Components of reimbursement

The reimbursement rate paid facilities will include the following two major components:

1. Operating costs

Operating costs are further divided into the following:

- a. Support costs - which include laundry, dietary, housekeeping, utilities, and administrative expenses.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related Reimbursement to Skilled Nursing and Intermediate Care Facilities

- b. Nursing costs - which include nurses salaries, utilization review expenses, and the cost of nursing, activity and related programs.
 2. Capital Costs - which include depreciation, rental costs and property taxes.
- B. Desk Review
 1. Costs will be reviewed annually with new rates being established for the beginning of the rate year. Ordinarily, the report used will be for a fiscal year ending at least one year prior to the beginning of the rate year, but less than two years prior to the rate year. Exceptions will be made in the cases of changes in ownership and other unusual cases.
 2. Non-allowable costs per II. D., will be adjusted out of the cost reports.
 3. Cost adjustments will be made to disallow costs attributable to excess capacity. The occupancy standard to be used in such adjustment is set at a level which minimizes excess capacity, but is attainable without adversely affecting accessibility of care. The median occupancy rate for the State as a whole in 1977, as represented on the State's cost reports was 93%, and will be used as the occupancy standard. Facilities having utilization levels below the standard will have their per patient day costs adjusted as if the occupancy were at the standard. For operating costs, a standard of actual or actual plus one-third of the difference between the actual occupancy and 93 percent, if the occupancy rate is below 93 percent. The one-third factor was calculated from the actual impact of occupancy on cost.

All cost reports will be grouped by HSA. (This grouping was determined after extensive analysis of wage rates which showed that no other geographic grouping factor explained more of the variance in wage rates, and hence facility costs.)

Operating Costs

 1. General
 - a. The per diem rate for operating reimbursement will be set prospectively and paid on a class basis. The class groupings are determined based on HSA area. There will, however, be a separate group for state operated MR facilities. (See page 57 of the Appendix.)

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related Reimbursement to Skilled Nursing and Intermediate Care Facilities

- b. The operating costs reported on the cost forms will be updated for inflation experienced since this cost report was filed and for inflation anticipated during the rate year, as follows:
 - i. The rate of inflation of nursing home costs from the two most recent cost report periods will be compared to CPI experience over the same period.
 - ii. The resulting factor, which might be larger or smaller than one, will be multiplied by CPI experience and projections from national economic forecasts, such as Chase Econometric, to obtain an expected rate of inflation from the period covered by the cost reports to the mid point of the rate year.
 - iii. Since it would be excessively difficult to change the rate during the course of the rate year, a single inflation factor will be used which will slightly overstate the amount of actual inflation in the first half of the rate year and correspondingly understate it in the second half of the rate year.
 - iv. Since this is the first year Illinois has had cost reports, only a small sample of facilities have submitted two complete cost reports. For the first year of the rate setting process, then, it is necessary to base the inflation factor on this sample of cost reports, rather than all cost reports. The above methodology, however, was applied to this sample to arrive at a CPI adjuster, which, in turn, was applied to actual experience and CPI projections for 1978. For further rate years, the CPI adjuster will be derived from comparisons of the cost experience of all facilities.
- c. In the event of minimum wage increases, it may be necessary to make further adjustments to account for the fact that the CPI does not necessarily allow for the particular labor composition of the nursing home industry. These special adjustments will be made by determining if the legislative mandated change has

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled Nursing and Intermediate Care Facilities

an impact greater than the increase in costs projected by use of the above inflation projections. These additional costs will be taken into consideration in the calculation of rates. For instance, the minimum wage increase of January 1, 1978, adds expenses to some facilities greater than the general CPI index might suggest. The specific adjustment for this change is calculated by dividing the difference between the regional average nurses aid salary updated for inflation as above, and \$2.75--ten cents more than minimum wage--by the updated minimum salary:

\$2.75 - (Updated Regional Average Nurses Aid Salary)
(Updated Regional Average Nurses Aid Salary)

Where the updated regional average nurses aid salary exceeds \$2.75 per hour, no minimum wage adjustment is made. The resulting percentage is multiplied by the estimated amount of total expenses due to non-administrative salary, based on the state's cost reports. The total expenses of each facility within the HSA are increased by that factor.

- d. These updated costs will be divided into two categories -- support costs and nursing costs. The actual figures used will be obtained from summing appropriate line items on the cost report.

2. Support Costs

- a. Support costs, include laundry, dietary, house-keeping, utilities, and administrative expenses will be reimbursed at actual costs up to the 50th percentile of all Skilled and Intermediate facilities in the HSA, including those reporting with no Medicaid patients.
- b. A facility experiencing support costs at less than the 50th percentile shall be allowed to retain one-half the difference between actual updated operating costs and the group ceiling. The same procedure shall also be applied to State MR facilities within their group.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled Nursing and Intermediate Care Facilities

3. Nursing and Program Costs

Reimbursement for nursing and program costs will be differentiated by the type of facility providing care. Three classification of facilities are to be recognized: skilled nursing (SNF) and intermediate care facilities (ICF); intermediate care facilities for the care of the mentally retarded (ICF/MR) and skilled nursing facilities for pediatrics (SNF/PED). State operated MR facilities are to be grouped separately, but essentially the same methodologies will be applied to them.

a. SNF and ICF facilities:

Each year, an estimate of nursing costs will be constructed using a two step methodology.

1. Standard nursing expenses will be estimated using statistical regression or closely related analysis. Factors to be considered in this analysis will be licensure or certification levels, average patient point count, an index representing quality of care delivered, ownership (public, non profit, proprietary), medicaid occupancy, percent occupancy, size, age of facility, geographical cost differences, and such other factors as the Department shall consider important and which have at least an 80% probability of influencing cost.
- ii. The resulting regression equations will be condensed into an administratively feasible reimbursement formula which will be the basis for calculating actual reimbursement. The resulting rates are group rates within those categories of difference incorporated in the equations. These rates will also include a base rate adequate to reimburse the minimum level of care of adequate quality.
- iii. An explanation of how this process operates is as follows (Specific figures are for purposes of illustration, and are based on the 1978 rate year nursing and program costs);
 - (A) A multiple regression equation is constructed on a random subsample of facilities which takes into account factors noted in 3a(i) above.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled Nursing and Intermediate Care Facilities

The regression equation used is:

Cost per Patient per day = Constant (Representing invariant cost of care) + A_1 x Skilled License + A_2 x Points + A_3 x Points² + A_4 x Quality Score + A_5 x County Ownership + A_6 x Voluntary Ownership + A_7 x Medicaid Proportion.

The resulting equations must be significant at the 80% level of probability or better.

In 1978, the regression equation was statistically significant and the variables included in the equation could account for about 60 percent of observed variance in nursing home costs. In other words, using the components of this equation, it was possible to assume within the normal ranges of statistical accuracy that about 60 percent of the costs varied with factors which were included in the equation.

Under the point count system, each patient is assigned points by a state reviewer at entry to the facility. Points are redetermined by state reviewers at least every sixty days for SNF's and at least every 90 days for ICF's.

This equation is condensed by combining all factors other than those likely to vary with patient characteristics - point score and skilled or intermediate level of care need - with the constant term. The multiple regression equation indicates that a reasonable estimate of increase in the daily cost of care for 1978 would be \$.24 per point up to 17 points. Above 17 points, each additional point would be expected to add \$.20 per day to cost. The regression also indicates that a reasonable estimate of the cost of providing a day of skilled care is \$1.88 above the cost of a day of intermediate care. The resulting reimbursement equation is:

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related Reimbursement to Skilled and Intermediate Care Facilities

$$R = $.24 P_1 + .20 P_2 + \$2.93 + \$1.88 S$$

Where, R = reimbursement
 P_1 = number of points through 17
 P_2 = number of points over 17
 and S = one for a skilled patient in a skilled bed, and 0 for all other circumstances.

Points here refers to scores awarded in the Department's assessment of patient need (see pages 58 through 65 of the appendix).

To illustrate how the reimbursement equation would be applied, consider a patient who is assigned 20 points by a Department of Public Aid caseworker upon entering a facility. Care would be reimbursed at:

\$2.93	base rate
4.08	first 17 points
<u>.60</u>	points from 18-20
\$7.61	

If, in addition, the patient had a condition which required skilled nursing care and occupied a skilled bed, reimbursement would be increased an additional \$1.88.

If the subject facility is in an area where the cost deflator equals 1.0, \$7.61 for an intermediate patient or \$9.49 for a skilled patient in a skilled bed would be the rate to be paid. If the deflator for the area was .9, for example, the rate would be multiplied by .9 to obtain the reimbursable rate--\$6.85 in the case of the intermediate patient.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled and Intermediate Care Facilities

It is worth pointing out that since all patients have some points, the actual minimum payment is larger than the base rate alone. For instance, 7 points is a very low point count for an ICF patient. This would, however, create a program reimbursement of \$4.61. Likewise, the usual cut off between SNF and ICF is 25 points so an average minimum SNF nursing reimbursement would be \$10.49.

b. ICF/MR facilities

ICF/MR facilities differ from other ICF facilities. Since they provide long term care to the developmentally disabled there is a much heavier training and program component provided and correspondingly the medical nursing services appear to be less intense. There is no reason to believe that expenses of ICF/MRs are directly comparable to those of ICFs, so the two are grouped separately.

At this time, there is no reliable historical data on the costs of providing ICF/MR care because recent implementation of revised licensing standards has increased staffing requirements. Accordingly, the cost related reimbursement approach adopted uses engineering or budget based estimates of costs as a basis for reimbursement. The specific approach used was the following:

- i. Licensing standards were reviewed with staff of the Departments of Mental Health and Developmental Disabilities and Public Health to determine staffing required by the new standards.
- ii. Relationships between staffing and costs were developed statistically, using data on average salary levels and non-personnel costs drawn from cost reports submitted to the Department of Public Health.
- iii. The resultant cost figures were related to scores generated by a patient assessment tool developed jointly by the Departments of Public Aid and Mental Health and Developmental Disabilities. The result is expressed as a dollars per point figure

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled and Intermediate Care Facilities

which may be used for reimbursement,
and which is expected to compensate
fully for the expense of meeting
licensure standards. (See pages 66
through 70 of Appendix.)

c. SNF/MR

SNF pediatric facilities treat children with a combination of severe medical and developmental problems. They thus deliver a combination of nursing and developmental services and, not being directly comparable to any other type of facility, will be grouped separately. Reimbursement will be similar to that for SNF and ICF facilities, with the following two exceptions:

- i. Because of the small sample size, regression estimates will not be reliable. Accordingly, the median program cost of the group will be used as the basis for group reimbursement.
- ii. An average cost per point on the existing point count system will be determined by dividing the median program cost - minus a base rate equal to minimum nursing costs - by the average point count in SNF/PEDs. For example, in 1978 unadjusted for regional differences, the SNF/PED base is \$10.79 and the value per point is \$.206.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost
Reimbursement to Skilled and Intermediate Care Facilities

d. State-operated MR facilities.

State-operated MR facilities will be grouped separately from other facilities, on the grounds that they serve a population which on average requires more intensive services, and on the grounds that these patients require more extensive support. The methodology for setting rates will be identical with that used to establish ICF-MR reimbursement.

D. Capital Costs

1. Capital expenses reported by facilities would be grouped on the basis of the average age of investment weighted by value of investment and geographical region. (see pages 71 and 72 of Appendix.) The formula for determining the average age of investment is

$$\text{Average age} = \frac{\sum_{i=1}^N A_i \times V_i}{\sum_{i=1}^N V_i}$$

where A_i = age of investment i
where V_i = cost of investment i
where N = number of investments

Five geographical regions have been identified within which capital costs appear to be similar; five time periods have similarly been identified. In the future, new groups will be created to encompass more recent construction whenever cost data indicates that such groupings are appropriate and the resulting groups would be large enough to provide a meaningful median cost figure. Thus, there are twenty-five potential groups into which a facility may fall. For the initial year, the year of latest acquisition prior to July 1, 1977, will serve as the basis for grouping rather than date of construction since data on original construction cost is generally

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related Reimbursement to Skilled and Intermediate Care Facilities

unavailable. In subsequent years, groupings will not change as a result of sales after July 1, 1977. That is, if a facility was built in 1972, sold in 1976, and sold again in January of 1978, it would be grouped in 1976 on the basis of 1976 being the last acquisition date prior to July 1977. It would remain grouped in the 1976 set despite the turnover in 1978. New construction, however, will be grouped with facilities constructed at the same time.

The average age of investment will be recalculated whenever renovation, construction, or new investment in equipment occurs. No recalculation will be made on the basis of refinancing without new real investment. The facility will change groups according to this reformulated average age for the purpose of capital reimbursement.

2. Once the facilities have been assigned to a specific grouping for purposes of capital reimbursement, the median capital expense will be calculated. This median will serve as the basis of reimbursement rates for all facilities in the group. The capital component of the rate will be calculated as follows:

- a) Facilities which have allowable per diem capital costs at or below the median will receive the median;
- b) Facilities which have allowable per diem capital costs between the median and the median plus ten percent of the median will receive the median plus 80% of the difference between their actual allowable costs and the median; and
- c) Facilities which have allowable per diem capital costs which exceed the median by 10% or more will receive the median plus 80% of the difference between the median times 1.10 and the median.

The 80% reimbursement factor is intended to provide an incentive to limit future capital cost increases.

For purposes of calculating capital expense, depreciation attributable to any asset will be allowed only once. After a change in ownership, only the useful life unclaimed by previous owners will be recognized

3. The group medians will be recalculated annually. Sales and the resultant increases in capital expense will be recognized in computing the median for each group in subsequent years, insofar as the increased capital expense is reasonable. No facility will move between groups on the basis of a sale. As a cost containment measure, the group rate will not be permitted to increase over the 1978 group year more than 125% of the proportion of CPI in the subject year over 1978 CPI. Group rate increases attributable to renovation, new construction, or investment in equipment shall not be subject to this

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable
Cost Related Reimbursement to Skilled and Intermediate Care
Facilities.

4. When additional investment is required to comply with State licensing requirements the facility may submit a request that the Illinois Department of Public Health certify the need for investment, specify the nature of the required investment, and estimate a range of reasonable expense for the specified changes. Such certification shall be provided or denied within sixty days from the request. When such certification is granted the facility shall be reimbursed for resulting per diem capital expense incurred in serving medicaid patients which, when added to other allowable per diem capital expenses is in excess of its group rate ceiling.
5. Factors which shall be employed in determining when additional groups shall be established are
 - (a) Size of group (with a target minimum of ten);
 - (b) Length of time since last group was formed (target limit of three years);
and
 - (c) Percent of difference of potential median of new group when either of above two criteria are met (target limit of ten percent).
6. The above subparagraphs 1-5 shall not apply to State operated MR facilities which shall constitute a separate group and shall receive the median capital cost for the group.

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reasonable Cost Related
Reimbursement to Skilled and Intermediate Care Facilities

- E. A reasonable cost related reimbursement system under this plan will be implemented for all long-term care facilities throughout the State participating in the Title XIX program not later than January 1, 1978, effective for services provided on and after that date.
- F. An opportunity for public review and comment on the proposed rates will be provided before they become effective. Copies of the State Plan and other related materials will be made available in each of the local Department of Public Aid offices. The public will be afforded an opportunity to submit written comments.

IV. Analysis and Audits

- A. All cost reports will be analyzed within six months of their submission. Where this initial analysis indicates the need for further audit, such audit will be undertaken.
- B. On-site audits will be made to verify the accuracy and reasonableness of reported costs to verify that only allowable costs are reported, and that expenses are properly attributed to allowable costs.
- C. Audit standards contained in HIM-18 will be adopted by the State.
- D. During the three years ending December 1980, at least one-third of the facilities participating will receive on-site audits of their financial and statistical records each year. All providers participating continuously during this three year period will be audited at least once during those three years.
- E. For the years beginning January 1, 1981, and later, on-site audits of the financial and statistical records of at least 15 percent of participating facilities will be conducted, including at least five percent selected on a random sample basis.
- F. Overpayments discovered as a result of audits will be accounted for on the OA-41 report, no later than the second quarter following the quarter in which the overpayment is found.
- G. After the completion of each on-site audit, a report of the Audit findings shall be retained by the State agency for a period of not less than three years following the date of submission of the report.

GUIDELINES FOR
EVALUATION OF NEED FOR CARE

The following guidelines are to be used by Department staff to determine point allowances and evaluate the need for care in group care facilities. Points are given, in each area of service listed below, on the basis of the highest level of services required and received by a recipient during the evaluation period. Points are allowed only for services provided by staff of the facility unless otherwise specified, as in the two point allowance in item 11. Points are not allowed for services recipients perform themselves or for services performed by individuals not employed by the facility, except where otherwise specified for individual items.

The evaluation is to be based on consultation with or written orders from the physician, personal observation of the recipient, and the facilities' record of services provided. In some instances casework staff are required to refer cases to the Regional Medical Assistance Consultant before allowing points or determining placement. Regional consultants are free to contact Regional Public Health Nurses, Department of Mental Health staff, or other professional medical or nursing personnel for consultation as needed.

A pound sign (#) in the criteria identifies services which require care in a skilled nursing facility. In addition, a recipient having a total point count of 25 points or more, on a continuing basis, requires skilled care. An asterisk (*) identifies services which require care in an intermediate care facility. Services not identified by either a pound sign or an asterisk may be provided in sheltered care facilities. Before authorizing care in a group care facility, an evaluation of other, more suitable, arrangements for care must be investigated. Care in a group care facility is to be approved only when there is no appropriate alternative.

1. Eating

- 0 - No point is allowed when the recipient is able to eat independently.
- 1 - One point is allowed when the recipient requires assistance in cutting food, buttering bread, placing utensils for blind recipient, etc.
- 2 - Two points are allowed when the recipient requires and receives some individual assistance in eating from a staff member. The assistance may vary from complete feeding on some days to partial feeding on others. Also included here is the type of assistance which can be given by a staff member to more than one patient in the same room during the meal.

- 2 -

- 4 - Four points are allowed when the recipient requires and receives complete individual attention by a staff member at all meals. The staff member remains in constant attendance at the patient's side throughout mealtime to hand feed the recipient or to insure adequate intake of food.
- *8 - Eight points are allowed when the recipient is unable to take food by mouth and tube feeding or gastrostomy feeding are given by licensed nurses on the physician's orders.

2. Mobility

- 0 - No point is allowed when the recipient is independent in movement with or without assistive devices and no assistance is needed to enable him to move from place to place. This includes the recipient who is able to transfer himself to and from a wheelchair.
- *2 - Two points are allowed when the recipient is able to move about but needs a staff member to assist him to get into a wheelchair, to begin walking with the walker; or to walk beside him to give assistance, etc.

May be allowed in a sheltered care facility for a recipient who can move about independently but needs assistance to get into a wheelchair or begin walking with a walker if 1) the facility is determined safe for the resident by IDPH, 2) the resident's quarters are on the first floor, and 3) access to the facility is at grade level or ramps are provided. Prior approval is required from the Regional Medical Assistance Consultant who will verify safety with IDPH.

- *3 - Three points are allowed when the recipient is unable to move about under his own power. He must be moved by a staff member. This may consist of pushing the wheelchair or lifting the patient. This also includes the recipient who is able to move except that his size or other physical condition requires that more than one nursing staff member be at his side to give assistance in moving about.

3. Behavior or Mental Condition

- 0 - No point is allowed for the recipient who is usually able to act in a manner that takes into account his needs and the needs of others and staff. He can be reasoned with and can adjust his behavior. On the whole, his behavior is consistently cooperative. He is aware of who he is and what is expected of him within the home. He does not require any special supervision.

- 3 -

3 - Three points are allowed for the recipient who requires occasional supervision from a staff member. He presents problems such as periods of hyperactivity or confusion, occasional strong reactions to frustrations or disappointments, prolonged periods of silence, excessive pacing or sleeping; or inability or unwillingness to interact. During such "ups and downs" he requires temporary support and vigilance from the staff.

*8 - Eight points are allowed for the recipient who requires special and continuous supervision by a licensed nurse. His tolerance is so low and unpredictable that a licensed nurse must be present in the facility at all times.

4. Current Physical Rehabilitation Needs

Rehabilitation nursing consists of services ordered by a physician, such as range of motion exercises, positioning, transfer activities, gait training, parallel bars, pulleys, and training of the aphasic. Bowel and bladder training programs are not included. The acute illnesses and injuries for which 8 or 12 points may be given include fractures of hip, pelvis, and extremities; acute brain trauma (to include spinal cord injuries or neurological disorders, but not to include congenital brain disorders); cerebral vascular accidents with resulting aphasia and/or hemiplegia; amputees requiring pre- and post- prosthetic care and training.

0 - No point is allowed for the recipient who does not require rehabilitation or who has no potential for rehabilitation.

*4 - Four points are allowed for the recipient who needs and is receiving rehabilitation nursing services, performed or supervised by a licensed nurse, to maintain current level of function.

*8 - Eight points are allowed for the recipient who needs and is receiving rehabilitation nursing services performed or supervised by a licensed nurse, following selected acute illnesses or injuries, to improve his level of functioning, for a period from three to six months following discharge from a hospital or rehabilitation facility.

*12 - Twelve points are allowed for a recipient who needs and is receiving intensive rehabilitation nursing services supervised by a licensed nurse following selected acute illnesses or injuries within a period of three months following discharge from a hospital or rehabilitation facility, if the facility has an approved rehabilitation nursing program.

5. Catheterization (including irrigations)

- 0 - No point is allowed when the recipient does not require catheterization or irrigation.
- *4 - Four points are allowed when the recipient requires an occasional catheterization for a specimen or treatment, or an indwelling catheter for a short term physical condition.
- *8 - Eight points are allowed when the physician orders a retention catheter to be used continuously. This also includes full care of the catheter and irrigations.

When a retention catheter is used the patient shall not be considered to be requiring or receiving care because of bladder incontinence under item 6, even though in some instances the patient may be on a bowel and bladder training program for a short period while the catheter is used.

6. Incontinence (Bladder and Bowel)

- 0 - No point is allowed when the recipient has complete bladder and bowel control.
- 1 - One point is allowed when recipient usually has control except on those infrequent occasions when he has an accident due to nervousness or visitors, or reaction to medications, such as cathartics.
- 2 - Two points are allowed when recipient is neither continent nor incontinent; sometimes he has control; other times he has none.
- *8 - Eight points are allowed for a recipient who needs and is receiving services to maintain bowel and bladder control following a bowel and bladder training program.
- *6 - Six points are allowed when the recipient has no bladder and/or bowel control and he requires care for cleanliness or comfort. This includes the patient who dribbles constantly.
- *8 - Eight points are allowed when the recipient has in the past had no control but is now receiving training through an active bowel and bladder program. The physician has ordered such a program and the nursing care plan for the patient includes this program (maximum length of time—initial period three months; if successful an additional three months; maximum total six months).

- 5 -

7. Douches, Enemas and/or Colostomy Irrigations

- 0 - No point is allowed when recipient does not require douches, enemas or colostomy irrigations, or requires and receives such service at infrequent intervals for the treatment of a short-term condition.
- *4 - Four points are allowed when the recipient requires and receives a douche, enema and/or colostomy irrigation on a regular basis but less than daily.
- *5 - Five points are allowed when the recipient requires and receives a douche, enema and/or colostomy irrigation at least daily.

When enemas are required and given on a regular basis, the patient is not considered, under item 6, to have bowel incontinence.

8. Diet

- 0 - No point is allowed when the diet ordered by the physician is the menu used for the majority of the patients in the facility, with or without minor modifications, such as removal of salt or sugar on trays, substitution of salads or desserts, etc. This includes pureed and baby food, or a mechanical (ground) diet.
- *3 - Three points are allowed when the diet ordered by the attending physician is a specific diet which must be prepared separately from the daily menu. This includes salt free, weighed or calculated caloric diets, and diets and tube feedings which require the purchase of special foods.

9. Medications (Oral, Drops, Ointments, Suppositories)

If a need for sheltered care is being considered the caseworker will determine whether the recipient is capable of handling his own medication, based on the physician's order, caseworker's knowledge of the recipient, and his past behavior pattern. The attending physician's order regarding the recipient's ability to self-administer medications will be the determining factor in deciding whether a recipient can handle his own medications. In instances where a recipient is taking more than two prescribed medications and is residing in a sheltered care facility, or is being considered for referral to a sheltered care facility, and the physician's order for self administration does not list all medications being taken, a listing of all medications prescribed for that individual is to be forwarded to the Regional Medical Assistance Consultant. A brief statement of the recipient's condition, including diagnosis, and the caseworker's recommendation regarding the recipient's capability of

- 6 -

handling his own medication is to accompany the list of medications. The Regional Medical Assistance Consultant will review the information and advise the county department in those cases where additional contact with the physician is recommended.

Prescribed PRN and variable dosage medications, controlled substances, and anticoagulants cannot be self-administered in a sheltered care facility.

0 - No point is allowed when medication is not prescribed, or the recipient's condition is such that the physician gives written permission for the resident to handle the medication himself. This includes supervised self-administration in sheltered care facilities.

*1 - One point is allowed for the recipient who requires and receives prescribed medication (oral, drops, ointments, suppositories) administered by staff on a less than daily basis.

*3 - Three points are allowed for the recipient who requires and receives prescribed medication (oral, drops, ointments, suppositories) administered by staff on a regular daily basis.

10. Injections (Hypodermic and Intramuscular)

0 - No point is allowed when hypodermics or intramuscular injections have not been prescribed by the physician or when a recipient is permitted to self-administer a drug by hypodermic on the written order of the physician.

*2 - Two points are allowed when hypodermics and/or intramuscular injections are administered on a less than daily basis by a licensed nurse.

*4 - Four points are allowed when the recipient requires and receives a daily injection of medication by a licensed nurse throughout the evaluation period.

11. Intravenous and Subcutaneous Fluids

0 - No point is allowed when the recipient does not require intravenous or subcutaneous fluids.

*2 - Two points are allowed when the recipient requires and receives intravenous and/or subcutaneous medication or fluids administered by the physician. (This allowance compensates the facility for supplies used.)

*8 - Eight points are allowed when intravenous or subcutaneous fluids are administered by a registered professional nurse upon the physician's order.

- 7 -

12. Suctioning

- 0 - No point is allowed when the recipient does not require suctioning.
- *3 - Three points are allowed when a recipient has a condition, such as a tracheotomy, to which he has become adjusted to such a degree that he is able to care for it himself with minimum assistance by nursing staff for cleansing purposes.
- *5 - Five points are allowed when the recipient requires suctioning less than daily.
- *8 - Eight points are allowed when the recipient requires suctioning daily throughout the evaluation period.

13. Oxygen (Includes Positive Pressure)

- 0 - No point is allowed when the recipient has no need for oxygen services.
- *4 - Four points are allowed when the recipient requires oxygen on an emergency basis or intermittently during the month. Also included is the recipient who is able to administer his own oxygen and/or positive pressure treatments with supervision and minimum assistance.
- *8 - Eight points are allowed when there is a current written order, and the recipient receives oxygen and/or positive pressure treatments on a daily basis, administered by nursing staff.

14. Dressings and Appliances

- 0 - No point is allowed when the recipient requires no dressings or requires only an occasional small temporary dressing for minor cuts or abrasions.
- *4 - Four points are allowed when the recipient requires daily application of Ace bandages, additional care because of a cast and/or assistance with the application of appliances such as prostheses, braces and supports.
- *6 - Six points are allowed when the recipient requires dressings to a moderate sized area and/or moist dressings or soaks, on a continuing basis. Such services may be required for, but are not limited to: decubiti; recurrent leg ulcers; and daily colostomy dressings.

- 8 -

- 48 - Eight points are allowed when there is a physician's written order for comprehensive dressings required on a regular daily basis, performed by a R.N. or graduate L.P.N.

15. Intermediate Care

- * - If services listed above do not indicate a need for either skilled or intermediate care, but the recipient needs services which must be provided or supervised by licensed nursing personnel, then intermediate care is required. When the need for such a service is identified by the caseworker or is pointed out by either the attending physician or facility staff and the caseworker verifies the need, a notation of the service which requires the licensed nursing personnel is to be made on the evaluation form and intermediate care is to be authorized. If the caseworker questions the need for licensed nursing personnel, the caseworker will refer the case to the Regional Medical Assistance Consultant for a determination of the level of care required. If intermediate care is approved a notation of the service which requires the licensed nursing personnel is to be made on the authorization form.

16. Skilled Care

- 4 - If services listed above do not indicate a need for skilled care but the recipient needs 24 hour licensed nursing care or supervision to meet specific needs indicated in his plan for care or an R.N. is required to assess the patient's needs and prepare the plan for care or a plan for the administration and/or control of medications such as narcotics or dicumerol, skilled care is required. When the need for such a service is identified by the caseworker or pointed out by the attending physician or facility staff, and the caseworker verifies the need, a notation of the service requiring skilled care is to be made on the evaluation form and skilled care is to be authorized. If the caseworker questions the need for skilled care, the caseworker will refer the case to the Regional Medical Assistance Consultant for a determination of the level of care required. If skilled care is approved a notation of the service requiring skilled care is to be made on the evaluation form.

17. Assistance with bathing: YES ☐ NO ☐
18. Assistance with dressing: YES ☐ NO ☐
19. Assistance with grooming: YES ☐ NO ☐

ICF/MR POINT COUNT GUIDELINES

ICF/MR Guidelines are to be used in Intermediate Care Facilities for the Mentally Retarded (ICF/MR) by the Departments of Public Aid (DPA) and Mental Health and Developmental Disabilities (DMHDD). DMHDD will certify each individual as an ICF/MR client. DPA will then apply these guidelines to each individual certified as an ICF/MR client by DMHDD to evaluate need for care and to determine point count assessment for payment. Points are given, in each area of service listed within the guidelines, on the basis of the highest level of services "required" and received by a client during the evaluation period.

The certification of need for care as an ICF/MR client is to be based on current diagnostic material and clinical judgment. Once a determination is made and a client is certified as an ICF/MR client, the evaluation for point count assessment is to be based on the results of the DMHDD certification/recertification, consultation with, or written orders from the physician, personal observation of the client, and the facility's record of services provided. In some instances DPA casework staff is required to refer cases to the Regional Medical Assistance Consultant before allowing points. Regional Consultants are free to contact Regional Public Health Nurses, Department of Mental Health staff, or other professional medical or nursing personnel for consultation as needed.

Before applying the ICF/MR Point Count Guidelines, a few symbols, words, and word phrases must be defined. For additional convenience, the defined words and word phrases are then italicized whenever they are used in the Guidelines.

A single plus (+) in the criteria indicates special program needs for an ICF/MR client. The client must exhibit a need for at least one of these programs to be eligible for ICF/MR certification and recertification.

A double plus (++) in the criteria indicates that special approval is necessary. A written specialized program must first be submitted to the Regional DD Coordinator for recommendations. The program and recommendations shall then be forwarded to the Division of Developmental Disabilities for consideration of approval or disapproval. Upon approval the Division shall, in writing, notify the Region/Subregion office of the point assessment. Notification of Division approval shall also be made in writing to the Region/Subregion. DMHDD will notify the local DPA office of the point assessment and effective date of the Specialized Program.

A *Structured Learning and Maintenance Program* is a systematic attempt to bring about behavioral changes which will maximize the client's ability to function independently. The structured learning program component concerns itself with skill acquisition; the maintenance component concerns itself with the continued performance of a skill once it has been acquired. The *structured learning and maintenance program* must:

- a. Be consistent with the "facility's general program plan," as submitted to the Department of Mental Health and Developmental Disabilities.
- b. Be supervised and conducted by "appropriate staff" as designated in the Minimum Rules and Regulations for ICF/DD.
- c. Include, in written forms in the individual client's record, clearly "defined goals" which detail the desired behavioral outcome.
- d. Include, in written form in the individual client's record, a "systematic plan" for achieving those goals.
- e. Include documentation which indicates the "frequency" of the client's participation in program sessions.

Unstructured Assistance involves staff interaction with the client which attempts to bring about behavioral change, but which lacks one or more of the elements required in a *structured learning and maintenance program*. To qualify under this definition, the staff interaction must meet at least requirements a. and b. of the definitions of a *structured learning and maintenance program*.

A client may be said to be *independent* in a given skill if he performs that skill under contingencies similar to those that prevail in the "normal" community.

Maintenance is a systematic attempt to encourage the continued performance of a skill.

A client may be said to *require* a program if it is determined to the satisfaction of the facility's interdisciplinary team that he is not *independent* in a particular skill, and further, that it is indeed desirable for him to acquire that skill.

1. Physical and/or Occupational Therapy

- 0 - Client neither *requires* nor receives physical therapy and/or occupational therapy.

- 8 - Client *requires* and is receiving physical therapy and/or occupational therapy services supervised by professional therapy staff.

2. Medication

- 0 - Client neither *requires* nor receives prescribed medication, or the client's condition is such that the physician gives written permission for the resident to handle the medication himself.
- 2 - Client *requires* and receives prescribed medication administered by staff.
- +5 - Client *requires* and receives prescribed medication which is administered by staff, but the client is also involved in a *structured learning and maintenance program* directed toward *independence* in the self-administration of prescribed medication.

3. Special Diet

- 0 - Client neither *requires* nor receives a special diet which varies from the menu used for the majority of clients in the facility, with or without minor modifications, such as removal of salt or sugar on trays, substitution of salads or desserts, etc. This includes pureed and baby food, or a mechanical (ground) diet.
- 3 - Client *requires* and receives a special diet prescribed by the attending physician and which must be prepared separately from the daily menu. This includes salt free, weighed, or calculated caloric diets, and diets and tube feeding which require the purchase of special foods.

4. Dressings

- 0 - Client neither *requires* nor receives dressings or additional care because of cast, etc., or client requires only an occasional small temporary dressing for minor cuts or abrasions.
- 2 - Client *requires* and receives application of dressings or additional care because of a cast, and/or assistance with the application of appliances such as prostheses, braces, and supports.

5. Maladaptive Behavior

- 0 - Client neither *requires* nor receives assistance in controlling maladaptive behavior. He can be reasoned with and can adjust his behavior. On the whole, his behavior is consistently cooperative. He does not *require* any special supervision.
- 3 - Client *requires* and receives *unstructured assistance* in controlling identified maladaptive behavior.

- +8 - Client *requires* and is involved in a *structured learning and maintenance program* directed toward controlling maladaptive behavior.

6. Social Habilitation and Activities

Social Habilitation and Activities include, but are not limited to the following programs: toileting, bathing, oral hygiene, grooming, dressing and/or undressing, personal possessions, eating, social skills, money management skills, and activities.

- 0 - Client neither *requires* nor receives assistance in social habilitation and activities.
- +3 - Client *requires* and receives *unstructured assistance* in social habilitation and activities which are supervised by professional habilitation staff.
- +5 - Client *requires* and is involved in a *structured learning and maintenance program* directed in social habilitation and activities which are supervised by professional habilitation staff.

7. Transportation

- 0 - Client neither *requires* nor receives assistance directed toward *independent use of public or non-public transportation*.
- +3 - Client *requires* and is involved in a *structured learning and maintenance program* directed toward *independent use of public and non-public transportation*.

8. Speech and Hearing

- 0 - Client neither *requires* nor receives assistance, or client is independent in speech and hearing skills.
- +4 - Client *requires* and receives *unstructured assistance* directed toward *independence* in speech and hearing skills.
- +6 - Client *requires* and is involved in a *structured learning and maintenance program*, directed toward *independence* in speech and hearing skills.

9. Equipment

- 0 - Client neither *requires* nor receives individualized, adaptive equipment.
- +3 - Client *requires* and receives individualized adaptive equipment as part of a *structured learning and maintenance program* directed toward *independence* in the use of this equipment.

10. Specialized Program++

+1-8 Program and points may be approved for clients requiring a specialized program for which specific provision has not been made above. (This point assessment must be reevaluated quarterly.)

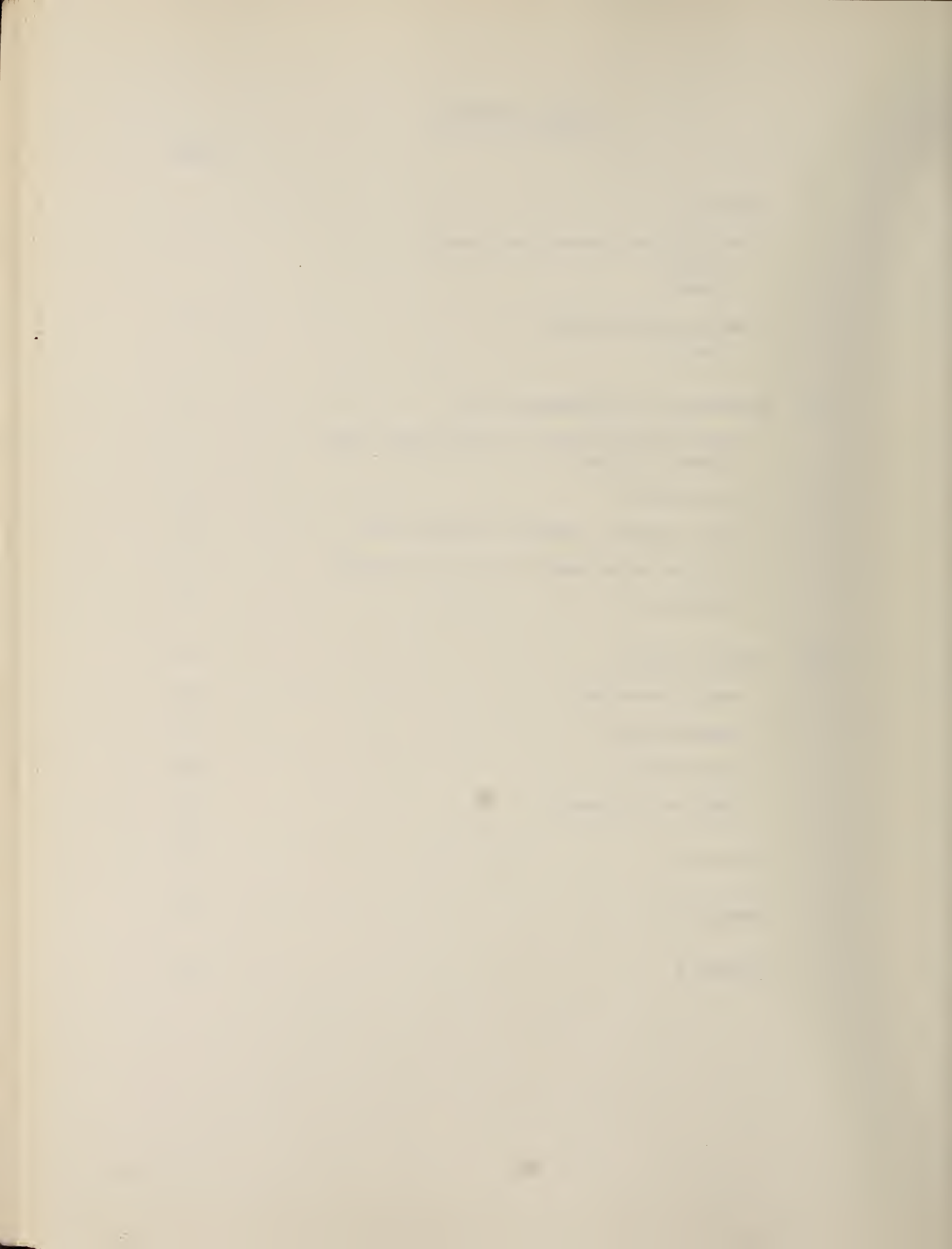


CALIFORNIA



TABLE OF CONTENTS

	<u>Page</u>
I. Introduction	1
The California Nursing Home Industry	2
Table 1	
Table 2	
Medi-Cal Reimbursement	5
Table 3	
II. Development of Reimbursement Policy	7
California Association of Nursing Homes versus Spencer Williams	8
Rate Cutbacks	10
Public Hearings: December 1970-March 1972	12
Flat Rate Reimbursement: 1972 to the Present	14
Proposition 13	17
III. Economic Analysis	19
General Incentives	19
Operating Costs	22
Capital Costs	28
Impact on the Industry	29
Footnotes	35
Appendix A	38
Appendix B	41



I. Introduction

Medicaid nursing home reimbursement policy in California has evolved under tight executive control and frequent judicial intervention. Executive control has been an outgrowth of both Governor Reagan's and Brown's emphasis on control over Medi-Cal^{*} expenditures. The central role of the courts is less easily explained. An examination of the history of reimbursement policy in California suggests that the courts have served as arbiters because compromise between the industry and the executive has not been possible.

Despite heated debate and a pending lawsuit over the details of Medi-Cal nursing home reimbursement policy, the outlines of that policy have emerged over the last few years--flat class rates based on median cost. The implications of this policy for quality of care, ownership arrangements, admissions practices, etc., are discussed in detail in Section III of this paper. This analysis suggests, however, that over the long run, reimbursement according to these principles will produce an industry which is small, efficient and heavily dependent on non-Medi-Cal subsidies.

* The California Medicaid program is known as Medi-Cal.

The California Nursing Home Industry

In 1976, there were 1,150 nursing homes with 97,796 beds in California. One thousand one hundred and fifteen of these homes were classified as skilled nursing facilities (SNFs) representing 95,963 beds. The remaining 35 homes, classified as intermediate care facilities (ICFs), had 1,833 beds (See Table 1). The average home had 85 beds. However, as shown in Table 2, over 35 percent of the homes had less than 59 beds. In addition, ICFs tended to be smaller than SNFs. Nearly 60 percent of the SNFs were corporately owned and another 26 percent were accounted for by other forms of proprietary ownership (See Table 2).

As in most states, Medicaid has been the principal purchaser of long-term care in California. In fiscal year 1975-76, payments to skilled nursing facilities amounted to over \$348 million, representing 15.7 percent of the total Medi-Cal budget of approximately \$2.2 billion.^{1/} ICFs received payments of roughly \$21 million during that year. Approximately 62,000 Medi-Cal recipients were receiving skilled care and 5,000 were receiving intermediate care.^{2/*}

Data concerning Medi-Cal's share of total industry revenues are imprecise. Assuming that all Medi-Cal patients stayed in the homes for a full year, that the private rates were equal to the Medi-Cal rates (which were, in March 1976, an average of \$19.93 a day for SNFs and \$16.04 a day for (ICFs), and that the homes' yearly census equaled Medicaid's 90 percent imputed occupancy, the 1976

*Nursing home operators may opt to certify five percent of their beds in a given licensure level at another level, i.e., an operator of a facility of 200 licensed SNF beds may certify 10 of those beds as ICF. This explains why the number of Medi-Cal recipients receiving intermediate care in 1975 (5,000) exceeded the number of licensed ICF beds (1,800). At the urging of the California Association of Health Care Facilities, operators have recently begun to refuse this option with the result that the state has been forced to reclassify patients from the intermediate to skilled care level (and thus pay for their care at the higher SNF rate) in order to place them in nursing homes.

Table 1

Number of Licensed Nursing Homes and Beds and Average Facility Size, 1966-1976

YEAR	SKILLED NURSING FACILITIES	SNF BEDS	AVERAGE BEDS/ SNF	INTERMEDIATE CARE FACILITIES	ICF BEDS	AVERAGE BEDS/ ICF	TOTAL NURSING HOMES	TOTAL NURSING HOME BEDS	AVERAGE BEDS/ FACILITY
1966	1,132	56,734	50	*			1,132	56,734	50
1968	1,168	73,303	63	*			1,168	73,303	63
1970	1,234	94,359	76	*			1,234	94,369	76
1972	1,190	95,793	80	17	647	38	1,207	96,440	80
1974	1,156	96,381	83	36	1,396	39	1,239	97,777	79
1976	1,115	95,963	86	35	1,833	52	1,150	97,796	85

3

* California did not license Intermediate Care Facilities separately until after 1970.

Sources: 1966-74: California Statistical Abstracts, 1976: Statewide Health Planning and Development Office.

Table 2

Skilled Nursing Home Ownership and Bedsizes Information

<u>Type of Ownership</u>	<u>Percentage of Facilities</u>	<u>Bedsizes</u>	<u>Percentage of Facilities</u>
Corporations	59.8	1-25	5.7
Individual/Partnership	26.3	26-59	29.9
Nonprofit	12.3	60-99	41.2
Public	1.6	100 plus	23.2
TOTAL	100.0		100.0

Source: Report of the Office of the Auditor General to the Joint Legislative Audit Committee, Long Term Care for the Aged (Part One): An Overview and Medi-Cal Reimbursements for Skilled Nursing Care, January 1977, p. A-1.

Medicaid expenditures accounted for 76 percent of the industry's total revenues. Those assumptions are, of course, mildly heroic.* Regardless of the exact percentage, Medicaid's financial involvement in nursing homes is considerable.

State control extends well beyond rates. California's regulation of nursing homes is divided among two state departments (Health and Benefit Payments) and one free-standing committee (the California Health Facilities Commission). The Department of Health as the designated single state agency for Medicaid establishes medical benefits, licenses and certifies facilities, and establishes provider reimbursement levels. The responsibility for the first three functions rests in the Medi-Cal Assistance Division, but the Rates and Fees Section is placed in the Administrative Division of the Department. The Health Audits Bureau of the Department of Benefit Payments performs audits of Medi-Cal providers. The California Health Facilities Commission is responsible for the design of uniform accounting, reporting and disclosure systems for nursing homes.

Medi-Cal Reimbursement

Since January 1, 1972, Medi-Cal has paid nursing homes on a flat rate basis. In 1977, the only year in which data availability permits cross-state rate comparisons, California's average SNF per diem of \$23.39 and ICF per diem of \$18.57 appear to have been on a par with the rates paid in other Pacific states. A comparison of California's rates with rates paid by states in all regions, however, reveals California's rates to have been relatively generous. Of the 32 states reporting, 11 paid higher rates on average to SNFs than California and 13,

*If Medi-Cal patient length of stay is less than a year, the 67,000 Medi-Cal patients represent less than 67,000 patient bed years; that is, they will fill fewer than 67,000 of 97,796 beds. If private pay rates exceed Medi-Cal rates, the number of Medi-Cal patients overrepresent their revenue potential. Finally, if the industry's occupancy rate exceeds the imputed 90 percent level, beds assumed to be empty will be filled with private pay patients; therefore, non Medi-Cal revenues will be larger than assumed above. In other words, Medi-Cal expenditures accounted for a maximum of 76 percent of the industry's revenues.

higher rates to ICFs. Because the states' rates are unadjusted for differences in wages, the cost of land, building etc., and because the cost of living in California is relatively high, this national comparison would tend to over-estimate the relative generosity of California's flat rates.

Table 3

Average Medicaid Nursing Home Reimbursement Rates,
First Quarter, 1977

	<u>SNF</u>	<u>ICF</u>
*California	\$20.39	\$18.57
Colorado	18.59	18.59
Nevada	24.00	22.00
New York	37.09	27.03
Oregon	20.77	16.35
Washington	17.85	15.75
Wyoming	20.97	18.87

Source: California rates are from the California Department of Health Services Rate Development Branch; all other rates are cited in "Program Rate Update, First Quarter, 1977" Memorandum from Wayne Franklin, CPA, to American Health Care Association State Executive Directors, April 15, 1977.

California currently classifies homes into six groups for reimbursement-- by care level (SNF, ICF) and by size (1-59 beds, 60-99 beds, 100+ beds). Each SNF class rate is equal to median incurred cost (adjusted for inflation) of facilities in that class, adjusted by an audit deviation factor (equal to a weighted average of percentage change in allowable costs as determined by audits of a sample of homes in that class). Rates are also adjusted to reflect the cost impact of changes in federal or state quality standards. The three ICF rates are determined by applying a factor of 80.5 percent to the comparable SNF rates. This system took effect on July 1, 1978 and contained a provision that during FY 1979, no facility would receive less than its rate on June 30, 1978*

*See Appendix A for a complete description of the current Medi-Cal nursing home reimbursement system.

II. Development of Reimbursement Policy

From the adoption of the Medi-Cal program in March 1966 until January 1972, nursing home reimbursement was nominally cost-related. Certain provisions of the reimbursement methodology underwent change; however, throughout most of the period, a facility's rate equalled the sum of its "departmental costs" (essentially operating costs) subject to a ceiling, and its "non-departmental costs" (essentially capital costs) subject to another ceiling. In addition, an overall rate ceiling was applied. Departmental costs were calculated at an imputed occupancy rate of 90 percent,* and administrative costs in excess of 15 percent of total departmental costs were disallowed. The ceilings on per patient day departmental costs decreased slightly with each additional bed in the facility according to a schedule issued periodically by the Department of Finance. Annual non-departmental cost reimbursement was set at 20 percent of the assessed values of the land, improvements and equipment (not to exceed \$8,000 per bed)^{3/}. This allowance was not as generous as it might first appear because: (1) assessed values were substantially lower than market values, (2) \$8,000 per bed is a very low estimate of the cost of nursing home construction and (3) the ceiling on non-department cost reimbursement (\$4.38 per patient day in all years) was quite restrictive. The ceilings on non-departmental costs and the overall rate ceiling also originated in the Department of Finance but were uniform across all facilities.

*Because actual average occupancy rates during this period were slightly below 90 percent (See "California Association of Health Facilities Position on Financial Aspects of Long-Term Care in California Assembly Health Committee Hearing on Nursing Homes"), this provision resulted in allowable per patient costs somewhat below the level of incurred costs.

California Association of Nursing Homes v. Spencer Williams

Throughout the period during which rates were cost-related, the sum of the ceiling on departmental costs (for all facility sizes) and the ceiling on non-departmental costs exceeded the overall rate ceiling. Though data are not available on the proportion of homes whose costs met or exceeded these ceilings, respondents indicated that the ceilings were sufficiently low to serve as de facto flat rates for most of the industry. Early in 1970, the California Association of Nursing Homes (which has since changed its name to the California Association of Health Facilities) filed a petition for a public hearing on reimbursement rates and policies with the Department of Health Care Services (the Department of Health since 1973). At the hearing, the Association presented evidence which it believed established the inadequacy of the rates. The Department, however, refused to make any changes in the rates.

An attorney for the Association commented that the public hearing had been requested solely to establish that the nursing home operators had exhausted administrative remedies before seeking a judicial one. It was widely known that the ceilings on nursing home rates were issued not by the Department of Health Care Services (DHCS) but by the Department of Finance;^{4/} indeed, these ceilings were published in the form of a pamphlet bearing the name of the Department of Finance and were incorporated into the regulations only by reference.^{5/} If power over rates had rested with DHCS, the nursing home industry might have been able to exert some influence over the rates. Administrative procedures which allowed the industry some access to DHCS (e.g., public hearings) were mandated. And more importantly, because DHCS was responsible for the quality and quantity of services provided recipients,

it had a vested interest in seeing that providers were adequately paid. The Department of Finance, on the other hand, had as its major function control of state expenditures;* it was not directly responsible for the quality of services purchased.

Given the administrative arrangements, it is not surprising that the industry made only a pro forma attempt to negotiate with the state, instead seeking relief from the courts. In February 1970, the California Association of Nursing Homes brought suit against Spencer Williams, Administrator of the Health and Welfare Agency, charging that nursing homes were not being paid "reasonable cost" as mandated by the Medi-Cal statute.^{6/} On appeal, the Sacramento Superior Court held that

The failure of the Medi-Cal administrator to hold hearings establishing an evidentiary record underlying Regulation 51511 thwarts judicial review of the regulation's compliance with "reasonable cost" standard and constitutes a substantial failure to comply with the procedural demands of the Administrative Procedures Act. It follows that the current regulation and its predecessors are invalid.^{7/}

The court's decision** on the validity of the regulations turned on the role played by the Department of Finance:

The [Medi-Cal agency's] adoption of the [Department of Finance's] fiat without independent consideration of the underlying evidence and without public or judicial access to it, transgresses fundamental demands for the adoption of administrative regulations.^{8/}

The Superior Court directed the lower court to issue a peremptory writ of mandate*** ordering DHCS to adopt valid regulations extending back to the onset of Medi-Cal (March 1966) after conducting public hearings in compliance with the Administrative Procedures Act.^{9/} The court also discussed CANH's claim to retroactive adjustment of rates following the adoption of valid regulations, but reached no clear decision.

*The Department of Finance was especially interested in minimizing expenditures during Reagan's cost-conscious administration.

**See Appendix B for the text of this decision.

***A premeptory writ of mandamus is an order directed by a superior to an inferior court to restore a complainant rights or privileges of which he has been illegally deprived.

Rate Cutbacks

Between the issuance of the writ of mandate in February, 1970 and the beginning of the public hearings in December of that year, several actions taken by the Reagan Administration in regard to nursing home rates brought the state and the industry into court again. First, in November, 1970, the Department of Health Care Services announced plans to create a new level of nursing home care to be called intermediate care. Medi-Cal nursing home patients found by a state survey team not to need constant medical attention were to be reclassified to the new level. The proposed maximum reimbursement rate for this care level was \$305 per month, \$120 less than the maximum payment for skilled care at that time.^{10/} Within a month, before industry plans to boycott Medi-Cal patients in an effort to prevent the creation of the intermediate care level had been acted on, Reagan announced his intention to cut future nursing home payments and to recapture a \$45 million "overpayment".^{11/} And finally, Reagan followed this announcement within a week with an order that Medi-Cal payments to all providers be cut by 10 percent.^{12/}

The industry's response was swift and predictable--litigate. During December, CANH filed suit to enjoin the first nursing home rate cutbacks. This time, however, they were not successful; a temporary restraining order was denied on December 14.^{13/} Only once judicial action had failed did the industry turn its full attention to political action--planning a massive Medi-Cal boycott. The nursing home industries in many states have at some time responded to unfavorable changes in reimbursement policy by threatening boycott; with sufficient publicity, the image of sick elderly people being turned away at the door can be a very damaging one for the state. What distinguished the boycott in California, however, was the remarkable degree

of cooperation among various sectors of the industry. When a boycott was first proposed, as a means of preventing the creation of an intermediate care level, supporters included only a portion of the members of the California Association of Nursing Homes. With the announced cut in the ceiling, the boycott gained the added support of the Multiple Facility Committee, representing chain operations.^{14/} And following the order to cut payments by 10 percent, supporters of the boycott included the entire membership of CANH plus some non-member facilities (for a total of 85,000 of the state's 92,000 nursing home beds^{15/}), the California Association of Homes for the Aging and the California Nurses Association.^{16/}

The planned boycott in California was to take an unusually dramatic form: in addition to turning away any new Medi-Cal patients, nursing home operators hired ambulances (100 in Los Angeles County alone) to remove the most costly, "heavy-care" Medi-Cal patients from nursing homes to county hospitals.^{17/}

The Reagan administration's response to this threat was to turn not to the press (as the administration was to do in Connecticut, for example), but to the courts. On January 31, one day before the scheduled boycott, the state successfully sought a temporary restraining order to halt the boycott on the grounds that participating nursing home operators would violate state anti-trust laws. Further court action in March replaced this temporary restraining order with a preliminary injunction banning wholesale transfer of Medi-Cal patients from private nursing homes. This order contained a stipulation that the industry would be free to press a legal battle against the state over rate levels.^{18/} Again, the importance of the courts in the development of reimbursement policy emerges; what the industry won in this compromise was not higher rates, access to rate-setters, etc., but the freedom to bring suit.

Although in March, 1971, the California legislature eased the cuts in Medi-Cal rates, ^{19/} the final solution to the controversy was judicial not legislative. The nursing home industry had not been the only provider group to bring suit over the cutbacks. The California Dental Association, the California Medical Association, and California Rural Legal Assistance had all taken their grievances to court in early 1971.^{20/} In June, 1971, the Sacramento Superior Court finally ruled in the CMA suit that the cutbacks had been unlawful in the first place.^{21/}

Public Hearings: December 1970-March 1972

In the midst of the furor over the rate cutbacks, the public hearings on nursing home regulations had begun. First on the agenda was Regulation 51511 covering nursing home reimbursement. Though the discussion was scheduled to last only several days, testimony on 51511 was taken on 50 days stretching over a period of 15 months.*

The proposed regulations discussed in the hearings laid out payment methodologies to cover the period from the beginning of Medi-Cal until 1971, as well as a new methodology to take effect in 1971. The historical regulations simply described the way nursing homes had been paid in the past, while the new regulations set forth a similar system of payment but with ceilings based on industry cost data collected by the accounting firm of Ernst and Ernst (under contract to the state). These cost data were to provide the evidentiary base the court had found to be lacking in the past.

During the hearings, the industry presented evidence in an effort to prove that (1) the methodology described in the historical regulations and continued in the new regulations was unreasonable, (2) the ceilings set

* An attorney for the Association suggested that though the hearings themselves may have cost the state close to \$1,000,000, the state saved far more than that in nursing home reimbursement during those 15 months. He argued that the state benefited from prolonging the hearings because the reimbursement system finally adopted at the end of those hearings allowed payment levels well above those of the old reimbursement system under which the nursing homes were paid for the duration of the public hearings.

forth in the historical regulations did not accurately reflect industry costs during that period and (3) the Ernst and Ernst data base was unacceptable because cost data were collected from a nonrepresentative sample of homes and were not properly audited and aggregated. Although a complete transcript was kept of the hearings, it was in off-the-record negotiations between the industry and DCHS that compromise positions were hammered out.^{22/}

In May, 1972, DCHS adopted final regulations. The form the compromise took is evident from the regulations themselves: regulations covering the period March, 1965 through January, 1972 were adopted exactly as proposed; the question of retroactive adjustment of rates was thus moot. However, regulations covering the period from January 1972 forward described a significant departure from the system originally proposed. Beginning January 1, 1972, the system of cost related payments constrained by a series of ceilings was replaced by a system of flat rates. In addition, these flat rates were based not on the data base prepared by Ernst and Ernst, but rather on cost data supplied by the industry. Although the industry has grown progressively less satisfied with the methodology used to calculate flat rates since 1972, they favored the switch to flat rate payments at that time. Not coincidentally, the first flat rate payment levels represented a significant increase over the rates the industry had been receiving prior to January 1972.

It is interesting to note that after years of failing completely to gain any ground with the Department of Finance, the industry was able to reach an acceptable compromise with DHCS.

Flat Rate Reimbursement: 1972 to the Present

Though the industry and the state continue to favor a flat rate system over a system in which an individual facility's rate varies with its costs,^{23/} the industry has become progressively less satisfied with the way the flat rates are calculated. The industry's primary complaint is that despite an established methodology for determining the rate levels and despite annual public hearings, the executive has secured increasingly tight control over rates. This control has been exercised directly, through gubernatorial veto, and indirectly through Department of Finance oversight of the Medi-Cal budget.

When Governor Edmund G. Brown, Jr. took office in January 1975, his pro-consumer stance was consistent with the concern then prevailing in the legislature that nursing home patients' rights be protected. As in other states, legislative interest in nursing homes increased dramatically with the wave of nursing home scandals in the early seventies. Although California did not experience scandal on the order of those in New York, for example, there was strong concern that measures should be taken which would preclude such scandals in the future. Thus, in 1973, the legislature enacted the Long Term Care Health, Safety and Security Act which established a "citation" system of fines to be levied against facilities which violated state quality standards. During the period following the adoption of this program, a strong adversary relationship existed between the nursing home industry and the standards enforcement agency of the Department of Health.

Within the past two years, however, many members of the legislature have become convinced (in part by intensive industry lobbying) that if the quality of care in nursing homes is to be upgraded, reimbursement levels must be increased. As the legislature has shifted the focus of its efforts to improve nursing home quality away from stricter monitoring of quality

toward higher payment levels, it has come into conflict with Brown's efforts to contain state expenditures. Brown has responded by using his veto.*

For example, in July, 1976, he deleted \$12.8 million earmarked for nursing home rate increases from the 1976-77 Medi-Cal budget. Later that year he approved a \$7.5 million appropriation to cover the cost of a 10 cent per hour wage hike for nonadministrative employees.^{24/} However, when the legislature passed a bill in 1977 providing for increases in reimbursement rates sufficient to establish parity between nurses aide wages in nursing homes and hospitals,^{25/} Governor Brown vetoed it.

While Governor Brown has kept the lid on nursing home reimbursements by using his veto, his Department of Finance has apparently held considerable sway over Health Department budget requests. The industry contends that under the previous system the Rate Development and Review Section of the Health Department manipulated the sample of facilities used to determine median cost, the costs reported by those facilities, and the inflation adjustment,^{26/} in order to keep expenditures within Department of Finance dictates. The State has argued that "the industry's contention that the Department manipulated data is a blatant misstatement. Until 1977 CAHF furnished the cost statements used for rate studies. All departmental calculations were checked by CAHF."** The Health Department's discretion in setting rates was considerably reduced in July 1978 when a new system requiring rates to be based on a 100 percent sample of industry cost reports went into effect. Previously, rates had been based on costs within only a small sample of Health Department selected homes--8 percent in FY 1978.^{27/} But even under the new system, audits are performed on only a portion of the cost reports (roughly 20 percent

* The California Assembly virtually never overrides a gubernatorial veto. (Interview)

** Correspondence to Jane Weeks from Henry Moody, Chief of the Rate Development Branch (undated).

were desk audited and 5 percent field audited in 1978^{28/}) in order to determine the audit deviation. (This figure is used to adjust median industrywide cost by the percentage change between reported and allowable cost in the audited sample). The industry also charges that they have supported legislation increasing input standards in nursing homes (e.g., nurses' aide training programs) with the understanding that rate increases would cover the full cost, only to have the Department of Finance limit the rate increase to well below additional incurred cost. And, finally, the industry charges that the most recent reimbursement system itself was designed in order to back into Department of Finance allocations.^{29/}

Staff in Rate Development and Review, on the other hand, contend that if there was any bias in the sample of nursing homes used in rate setting, it must have been in favor of the high cost homes. Because the facilities contacted for cost data were under no compulsion to provide it, some self selection toward high cost homes undoubtedly occurred. Similarly, they feel that the conditions of Assembly Bill 1426, which requires that rates be increased to cover the cost of complying with changes in licensure requirements, have been fully met. It should be noted, however, that staff of several legislative committees supported the industry's argument. One long-time Senate Health and Welfare Committee aide reported that, to his knowledge, the requirements of AB 1600 had never been met, and an aide to the Assembly Health Committee reported that there is a general feeling among the members of that Committee that within the executive the Department of Finance's concern with containing expenditures has been given priority over the Department of Health's concern with quality and quantity of care. Whether or not these perceptions are accurate, they help explain why the relevant legislative committees have been unusually aggressive in supporting increased reimbursement for nursing homes.

Proposition 13

From October 1971 through June 1978 the state's portion of Medi-Cal expenditures was funded by state revenues and a county contribution equal to a fixed percent of assessed value of taxable real estate in each county.^{30/} This contribution amounted to roughly \$460 million a year.^{31/} In response to the passage of Proposition 13 in June 1978, (Proposition 13 lowered the maximum annual property tax from 3 to 1 percent of assessed value) the California legislature acted to "buy out" the county contribution to Medi-Cal during fiscal year 1979. In other words, the state relieved the counties of their responsibility to share in Medi-Cal funding in an effort to lessen the impact of Proposition 13 on local services. Whether this "buy out" will become permanent has not yet been decided.^{32/}

It is in this context that the reimbursement system which went into effect July 1, 1978 must be considered.* This system, like the one which preceded it, sets SNF flat rates in each of three size ranges at median cost, and ICF rates at 80.5 percent of the comparable SNF rates. It departs from the previous system in the following ways: (1) the sample from which median cost is derived consists of all SNFs in that size range rather than a proportion of those facilities, (2) each facility's base year costs are updated using the lesser of actual cost changes and the California CPI before the median is determined (under the previous system the median of uninflated costs was updated using the California CPI), (3) the return on equity component (equal to the Medicare rate of return applied to average net equity in the rate setting sample) has been eliminated, and (4) each facility is guaranteed a rate no lower than its rate on June 30, 1978. This last provision applies only to FY 1979 rates.

* See Appendix A for a complete description of the current Medi-Cal nursing home reimbursement system.

After determining that the implementation of this system meant little or no rate increase in FY 1979, the California Association of Health Facilities filed suit on July 14, 1978 in an effort to have the system declared illegal. Naming the California Health Department and HEW as defendants, CAHF charges that setting rates according to the system is illegal because (1) the system has not received HEW approval as required by Section 249, (2) a system which sets rates equal to median cost cannot be considered "reasonably cost related" (as required by Section 249) because half the facilities then have costs higher than the rate, (3) the absence of any return on equity component violates the "intent of Section 249 that equity capital reimbursement be permitted," (4) the audit and inflation adjustment procedures violate various provisions of Section 249, and (5) reimbursement levels are based on legislative appropriations in violation of Section 249 requirements. Again it should be noted that these are allegations and as such are subject to rebuttal, fact-finding and judicial interpretation.

Whether the industry succeeds in forcing the redrafting of the reimbursement system will depend on the courts' interpretation of the complex history of the implementation of Section 249 and the often ambiguous wording of these regulations. Once again, the future of nursing home reimbursement policy in California rests not with public policy-makers, who are most knowledgeable about these issues, or even with elected representatives, but with the court.

III. Economic Analysis

General Incentives

Under a flat rate system, an operator maximizes his profits by minimizing his costs. The greater the difference between a home's costs and the flat rate, the greater the profits or losses. If the flat rate is based on providers' incurred costs, as it is in California, providers in the aggregate can increase future payments by increasing current costs. However, an individual provider's effect on average cost is so small that in the absence of collusion he has little incentive to increase real costs. In fact, an increase in costs is penalized by a reduction in profit. A cost-based flat rate does create an incentive to increase costs per books, however, if this can be accomplished, through disguising profits as costs, without increasing real costs.

While flat rate reimbursement may prompt cost minimizing behavior in the private home, it may give the appearance that the state is supporting excessive profits in some homes. This is because incremental changes in the rate result in large costs (or savings) and produce major responses by the industry. For example, if an increase in Medicaid beds is required, the state normally must increase the rate. As a result, it will encourage homes to either switch some existing beds from formally higher paying private patients to Medicaid patients and/or it will encourage the addition of new beds to the stock. Regardless of where the increase comes from, the cost to the state as the major purchaser will be in excess of the cost of the additional beds made available to Medicaid. For example, a state may have 1,000 Medicaid beds for which it pays \$20 per bed per day. If the state wishes to expand its supply to 1,100 beds, it must raise its rate to \$22 per day, the estimated cost the state must pay in order to encourage an entrepreneur to build

and operate the 1,100th bed. When the state raises its rate to \$22, it pays a \$2 per patient day increase to the 1,000 pre-existing homes. The cost to the state for attracting these 100 beds into the market is $\$2 \times 100$ plus $\$22 \times 100$ or \$4,200. Thus, in this example, the additional 100 beds effectively cost the state \$42 per day. Further, the increase in Medicaid rates will most likely bid up the private pay rates, thereby increasing the rate at which private patients deplete their resources and become eligible for Medicaid. Finally, the impact of the new beds will not have a uniform effect on existing facilities because of differences in proximity to the new nursing home, differences in profit/non-profit status, organization and administrative expertise. Some homes will immediately feel the competitive pressure and will incur the costs necessary to maintain their patient census or incur the loss of patient revenues. On the other hand, some homes' costs will be unaffected by the additional beds, and consequently, the rate increase will be a bonus for them.

This discussion of the dynamics of flat rate pricing may shed some light on the recurrent charge that it is intrinsically unfair to set rates at median cost because half the industry will then have costs in excess of that flat rate. From an economic perspective that political attack on flat rate is overly simplistic. In the absence of barriers to entry, flat rates act as a marginal pricing mechanism that is over the long run they will equal the marginal cost of bringing the last Medicaid bed into production. This does not mean that the state consciously sets the rate with a target number of beds in mind, but that the effect of the flat rate, regardless of how it is set, is to attract investors until the cost of the last bed brought into production is the flat rate.

Nor do flat rates as a marginal pricing tool mean that owners will immediately increase the size of their homes by one bed for a given increase in the rate. The bed stock is the least flexible component of the nursing home industry. Investors may be willing to build new homes of only 100 beds or more, for example, or to add onto existing structures in units of 25 beds or more. Further, because of the time lag between the decision to build and the actual completion of the new beds, the response to an increased rate may not be seen until two or three years after that rate increase was first issued. Similarly, because nursing homes are single purpose structures functioning in heavily regulated sectors, an owner may find it difficult to exit immediately from the market (by either shifting the home to another use or selling). Thus, the result of an effective decrease in the flat rates on the industry's supply of beds may not become apparent for a year or two after the rate changes. Further, incremental rate changes may be viewed as short term phenomena, insufficient to produce any changes in the industry's bed supply. In this case the industry would adopt a wait and see posture, enjoying short term gains (or absorb short term losses) and act once the rate changes become perceived as being part of a long term trend.

The decision as to how a firm will allocate its existing beds between Medicaid and non-Medicaid patients is directly linked to the relative revenue potential of both markets. In most instances, the allocative response by the homes could be more rapid than decisions to build or disinvest because the ability to reallocate is constrained only by the availability of unoccupied beds and the rate of patient turnover. Thus the state could experience a more immediate change in the availability of Medicaid beds without any net change in the bed capacity of the industry.

Normally, extremely large profits throughout the industry would be a short run phenomenon which would signal other investors to build nursing

homes, increase competition and reduce excessive profits. (This assumes that in addition to absence of barriers to entry the state actively monitors the financial condition of homes and acts as a prudent buyer.) If the state increases rates without regard to actual cost experience, then the state can support excessive profits over time. Average costs which over time are in excess of the flat rates reflect the use of charitable subsidies and the existence of more lucrative private pay patients. Flat rates equal to median cost are unfair only if it is unfair to permit (1) differences in the style of operation between profit and non-profit homes,* (2) differences between the quality of care provided to some private pay patients and level of quality provided to public patients, (3) subsidization of Medicaid patients by private pay patients, or (4) intra-state differences in costs between urban and rural communities.

Other potential problems and advantages of flat rates in general, and California's flat rates in particular, are discussed below in terms of the incentives they create with respect to operating and capital cost expenditures as well as their long-term impact on the industry.

Operating Costs

A proprietary provider's sole source of profit under a flat rate is the difference between that rate and his average cost. Therefore, to maximize profit he will minimize costs. In terms of variable costs this means limiting services, staffing levels, salaries, etc., to the lowest level necessary to retain licensure and certification.

*See pages 27 and 28.

What are the implications for quality of care? A definitive answer is impossible in the absence of a generally accepted definition of quality of care. However, a measure of the potential to provide high-quality care may serve as a proxy. Such a measure might consist of the number of effective nursing hours per patient per day, the extent of services offered and the per patient expenditures on food. As indicated, the economic incentive under a flat rate system is to maintain the lowest levels along each of these dimensions permitted by licensure and certification standards. Thus, the reimbursement system encourages a decrease in the potential to provide quality care.

If there is no competition within the nursing home industry, i.e., if every operator can maintain continuous 100 percent occupancy, there is no incentive to provide higher quality and more extensive services than required by the quality enforcement agency. However, the existence of competition will to some extent offset the incentive to minimize quality. First, because fixed costs do not vary with volume, an increase in occupancy results in a spreading of these costs over a larger population, i.e., a reduction in average cost. Therefore, a provider must weigh the cost of increasing quality and scope of services against the potential for increased profits which may be realized if an increase in demand results in lower average total cost (unit cost). This argument becomes somewhat attenuated when placement decisions are placed in the hands of social workers or other third parties who may have more pressing priorities (e.g., rapid placement) than quality.

Second, independent of its effect on occupancy, the proportion of private pay patients in a facility will affect profits. Private pay patients typically pay more than Medicaid pays, demand more than Medicaid requires, and generate greater profits than Medicaid generates. If homes are to attract private patients, they must offer care at a level equal to or higher than other homes competing for those patients.

The strength of these incentives will vary with the level of reimbursement. The higher the payment rates, the greater the likelihood of competition, and thus the stronger the incentive to increase quality in order to attract patients. In other words, as long as entry is unrestricted, increases in the flat rate will attract new beds and theoretically produce quality increase over the long run. In practice, this effect will depend on the geographic dispersion of facilities (i.e., the addition of new beds to the stock in one region of the state will heighten competition for patients within that region), and the array of factors other than the level of reimbursement (access to capital, nursing home scandal, etc.) which influence the decision to enter the nursing home market.

An increase in the level of reimbursement may affect demand as well as supply. If the income eligibility standard for Medicaid nursing home care equals the Medicaid reimbursement level* (as it does in California), a rate hike will serve to expand eligibility. The resulting increase in Medicaid demand will reduce the impact on quality of any supply expansion caused by the rate increase. Again, this effect is subject to geographic variation; in areas in which a significant number of persons have incomes just above

*In states which extend Medicaid eligibility to the medically needy, permitting them to "spend down" into eligibility as California does, the reimbursement rate establishes the state-recognized price of care and thus serves as the effective income eligibility level.

the existing reimbursement level, a rate hike will have a much greater impact on demand than in areas where the majority of elderly persons have incomes which place them either below or well above the reimbursement level. Thus, in practice, the extent to which an increase in the flat rate will spur an increase in nursing home quality will vary with location (proximity to new entrants), the strength of other constraints on supply expansion, Medicaid eligibility policy, income distribution within the elderly population, etc.

Flat rate reimbursement also creates incentives with respect to patient admission and care. The system rewards providers for selectively admitting patients for whom they can care at the lowest possible cost, i.e., the "healthiest" (least impaired, least disruptive) patients. Spokesmen for the state and the industry identified this incentive as one of the most significant disadvantages of the flat rate system in California. The state is concerned not only with the hardship imposed on heavy care patients for whom nursing home beds cannot be found, but also with the cost of keeping such patients in hospitals. In January 1977 alone, Medi-Cal expenditures on "administrative days" (medically unnecessary hospital patient days) were \$2 million.^{33/}

One way to counter this trend is to set flat rates according to patient impairment.* For nearly a decade, Illinois, for example, used a reimbursement system which assigned points to different levels of patient debility and dependence and then reimbursed the home on the basis of the point count rather than on the classification of the homes per se**.

*In response to the state Auditor General's recommendation (in Long-Term Care for the Aged: An Overview and Medi-Cal Reimbursements for Skilled Nursing Care) that nursing home reimbursement rates be linked to patient care needs, the Office of Planning and Program Analysis of the Health Department undertook, in March, 1977, a study of "prescriptive" rate setting. After examining patient impairment-based systems in other states, this office proposed a prescriptive rate setting method. In the opinion of OPPIA staff, however, the proposed system's cost and complexity make its adoption very unlikely.

**The Illinois system had three components: a base rate paid for all patients; the point count reimbursement; and an add-on for special services.

becomes practical only if there is consensus over the measurement of impairment, if the measures are linked to expected costs, if the system can be administered fairly and consistently, and if the administrative expense of continual monitoring and rate adjustment is less than the excess burden that public facilities incur in servicing high cost patients.

Once providers have "creamed" these patients from the pool of persons seeking admission to a facility, the incentive is to care for them as cheaply as possible. While a healthy person will require less nursing care than one whose functioning is impaired,^{34/} the cost of retarding deterioration in patient condition (i.e., providing therapy and restorative services) may exceed the resultant savings on nursing care. Thus to the extent that keeping patients healthy and rehabilitating impaired patients costs the operator more than he will save as a result in routine service costs, the payment system encourages him to allow patient condition to deteriorate.

The discussion so far has concentrated on the disadvantages of flat rate reimbursement; it also has significant advantages over a system in which rates vary with the individual provider's costs. As indicated, flat rates enable the state to retain tighter control over reimbursement expenditures. In addition, they are far easier to administer (thus reducing the state's administrative costs) and allow more accurate budgeting by the state and the provider. And finally, they create a strong incentive to providers to operate efficiently. Cutting back on operating costs does not necessarily result in a reduction in quality. The flat rate system undoubtedly induces operators to seek purchase discounts, eliminate wasteful administrative practices, encourage employee productivity, etc. To the extent that these

efficiencies permit operators to spend more generously in areas directly related to patient care, the incentive to operate efficiently may benefit patients as well as the state.

Assuming that the objectives of non-profit providers differ from those of proprietary providers, they can be expected to behave somewhat differently under the system. Proprietary providers seek to maximize profit; the objectives of non-profit providers are less easily identified. The conventional wisdom is that non-profit operations seek to maximize some unknown function of quality and quantity.^{35/} For example, a non-profit institution serving a clearly defined, limited population (e.g., the members of a fraternal organization) may have no desire to expand so long as it can provide sufficient beds to meet demand within that population and thus will have as its primary objective to increase quality. Another provider may be willing to sacrifice quality in order to serve as large a population as possible.

From these objectives it follows that a non-profit provider whose patient population is 100 percent Medicaid and who has no other source of income will seek to incur costs at a rate exactly equal to Medicaid's reimbursement. Higher average costs would put him out of business; lower costs would result in a surplus. Because of his non-profit status this surplus could not be distributed, but would have to be put back into the operation thus increasing per patient expenditures to the level of the state's payment.

Few non-profit operations rely solely on Medicaid revenues, however; most care for some private pay patients and most have charitable contributions and endowments on which they can draw. Under these conditions they can be expected to pursue the targeted levels of quality and quantity as far as their various sources of income will allow. Assuming there is no limit to non-profit

providers' desire to expand beds and/or services, they can be expected to spend at rates in excess of the reimbursement level until the pool of charitable contributions allocated for the current period is depleted.

Capital Costs

Incentives facing a proprietary provider with regard to capital expenditures are the same as those outlined in the preceeding sections: minimize costs subject to the conditions described above. If degree of facility maintenance and restoration, amount of land and square footage per patient can be used as quality measures in the area of capital costs, then providers can be expected to reduce quality, i.e., allow facilities to deteriorate, build on the smallest tract of land possible and keep square footage to a minimum, except to the extent that this results in lessened occupancy and reduced private pay revenues.

A flat rate payment system rewards efficiency with respect to capital expenditures as well as operating cost expenditures. Examples of efficient capital cost behavior which have no negative effect on quality of patient life or care are seeking to obtain the lowest possible mortgage interest rate, accepting competitive bids on facility construction, and substituting labor for certain expensive pieces of equipment. Non-profit providers could be expected to operate efficiently as well; savings could be used to increase quality and size. Again, if efficient capital cost behavior permits operators to spend more generously in areas directly related to patient care, the incentive to operate efficiently may benefit patients as well as the state.

The reimbursement system creates incentives for the financing of capital as well as for real capital investment. The investment decision requires not only the choice of a level of total investment (which determines an owner's assets) but also the apportionment of that investment between the investor's own and borrowed funds (which determines his equity).

Medi-Cal adheres to the rules of Medicare's Health Insurance Manual-15 (HIM-15) in determining allowable nursing home costs. If an owner borrows the money to finance his facility he may claim depreciation and the interest on his mortgage as allowable capital costs. If he invests his own money he may claim only depreciation (the current Medi-Cal system makes no provision for return on equity). The decision to finance rests on a comparison of the mortgage interest rate (i.e., the cost of borrowing) with expected rates of return in other markets (i.e., the cost of investing in the nursing home). There is another factor which the investor must consider, however. It is possible that a provider may increase the flat rate by as much as his incurred interest if he borrows. In general, if a provider whose costs exclusive of interest are below the median incurs interest (per patient day) of at least as much as the difference between his other allowable costs and the rate, the rate will shift up. As a result, the reimbursement system creates an incentive to borrow rather than invest capital, an incentive greatly reinforced by strong tax incentives in the same direction.

Impact on the Industry

The nature of the reimbursement system has implications not only for the behavior of existing facility owners and operators, but also for changes in characteristics of the state's industry over time. One would expect to see a trend over the long-run toward an industry composed primarily of the types of facilities which fare best under the reimbursement system.

A flat rate system rewards operators for minimizing average cost. Industry-wide trends toward facilities with characteristics associated with lower average cost should occur under prolonged flat rate payment. For example, to the extent that rural facilities face lower land, supply and labor costs,

they enjoy an advantage over urban facilities under a statewide flat rate (this advantage may be offset somewhat by greater demand in urban areas).

In general, to the extent that demand distribution permits, facilities should become concentrated in lower cost areas of the state. In fact, several studies of the California nursing home industry have identified a growing problem of access to Medi-Cal beds in high cost urban areas.^{36/} All that is necessary to insure a more even distribution of beds is to disaggregate facilities by region in setting flat rates.

Observers of the California nursing home industry have noted a second trend: away from independent ownership toward multi-facility operations. The scale of the multi-facility operations gives them an advantage over independent operators in securing purchasing discounts, exercising leverage in hiring, establishing contacts within hospitals and other institutions responsible for referrals, and hiring full-time staff to solicit patients. These advantages lead directly and indirectly, through higher occupancy rates, to lower average costs.

Average cost may also vary with facility size. The assumption that there are economies of scale in nursing home operations presumably shaped the schedules of maximum departmental costs (operating costs) during the period of cost related reimbursement (1966-1971). These ceilings decreased with each incremental increase in facility size. Under flat rate reimbursement these incremental differences have been collapsed into size ranges: 1-59 beds, 60-99 beds, and 100+ beds. Not surprisingly, median costs have historically been lower in the 60-99 bed range than in the smallest facility category, and lower in the 100+ bed range than in the 60-99 bed range. Facilities undoubtedly adjusted per diem costs on the basis of the cost ceilings in effect through

1971; apparent economies of scale since that time may simply reflect the lingering effect of the schedule of maximum departmental costs. Some preliminary evidence exists that after several years of flat rate reimbursement equal to median cost, diseconomies of scale are beginning to appear.^{37/} As long as rate setters permit reimbursement levels to float with median cost, major trends in average facility size will be uninfluenced by reimbursement policy. (Given continuous diseconomies of scale, however, it may be most profitable to operate a facility which is at the low end of each size range.)

The overwhelming predominance of SNFs in California (93 percent of Medicaid patient days were at the SNF level in 1976; 7 percent at the ICF level) suggests that, historically, it has been more profitable to provide SNF care. Clearly, a potential provider's decision as to which care level to build and operate will depend on a comparison of the long term reimbursement rate/average cost ratios of the two levels. The structure of California's industry suggests that this ratio has been higher for SNFs than for ICFs, i.e., that the 19.5 percent differential between SNF and ICF rates overestimates the cost difference between the two levels.

The preceding arguments suggest that if reimbursement policy remains unchanged, the industry will continue to exhibit a trend toward rural SNFs, at the lower end of each size range under multi-facility ownership. The continued use of a system of flat rates equal to median cost may have a more profound effect on the industry, however. To predict this effect, it would be necessary to know: what happens over time to those facilities which are consistently in the 50+ percentile of the array, how providers alter their behavior in order to maximize profits or revenues over time, and how changes in the industry will affect the median over time.

Setting the rate at the median is, by definition, setting the rate so that half of the facilities in the class have incurred costs above the rate and half below. This is a slight oversimplification, however, which ignores the cost of capital--a true cost for any investor. A proprietary provider whose entire census is Medi-Cal will incur true costs in excess of the rate unless the rate is equal to or greater than the sum of his average departmental costs, average non-department costs and a reasonable rate of return (i.e., the rate of return in another market of comparable risk) on his equity. In other words, all non-profit providers with total allowable costs greater than the rate and all proprietary providers with total allowable average costs greater than the rate less a reasonable return on equity will operate at a loss on each Medi-Cal patient. Thus, slightly more than half the facilities in the state will have costs in excess of the rate in any one year.*

As the earlier discussion of flat rates as marginal cost pricing mechanisms demonstrated, paying at the median is not necessarily unreasonable in an industry in which subsidies (from private pay patients and from charity) have always been prevalent. It does follow, however, that every provider who is consistently below the breakeven point must rely on one or both kinds of subsidies to survive. In other words, under prolonged flat rate median cost reimbursement, all facilities above the median must be non-profit operations with charitable funds or have private pay populations sufficiently large to cover the deficit incurred in caring for Medi-Cal patients.

The relative proportions of public and private pay patients necessary to keep revenues in excess of costs is a function of the relationship between the Medi-Cal rate and average variable cost, and the relationship between average total cost and the private pay rate. Clearly, if a provider's average

*Because of the various incentives to mortgage (see discussion of financing of capital) equity in California nursing homes is negligible (Interviews). Therefore, the percentage of facilities with costs in excess of the rate may be only slightly more than 50.

variable cost exceeds the Medi-Cal rate, he will not participate in the program. And if his average total cost is met or exceeded by the rate, subsidy will be unnecessary. But, if the Medi-Cal rate is greater than average variable cost and less than average total cost, he can still operate at a profit. This is possible if the excess of the private pay rate over average total cost times the number of private pay patients exceeds the excess of average total cost over the Medi-Cal rate times the number of Medi-Cal patients:

$$PP(R_1 - ATC) > MC(ATC - R_2)$$

PP: number of private pay patients

MC: number of Medi-Cal patients

R_1 : private pay rate

R_2 : Medi-Cal rate

ATC: average total cost

Those facilities in the upper half of the cost array which are unable to secure sufficient revenues from non-Medi-Cal sources will be forced to leave the market. With each firm that leaves the market, the median will shift down; e.g., if ten firms in the upper half of the array leave the market, the median will shift down until five firms which had previously fallen below the median, move above the median. This process will continue until the industry reaches an equilibrium in which at least half the firms are either non-profit operations willing to subsidize Medi-Cal patients with charitable funds and/or private pay patient revenues or proprietary operations with a sufficient number of higher paying private pay patients to subsidize Medi-Cal patients.

Of course the industry may move toward this equilibrium from below as well as above. If private pay demand is sufficiently strong to support high profit margins throughout the array (below as well as above the median), new firms can be expected to enter the market (assuming no barriers to entry) until the equilibrium described above is reached. It bears repeating that in this equilibrium state, all the firms are earning total revenues equal to or in excess of costs despite a Medi-Cal rate which is lower than the average total costs of at least half the facilities in the state.

The existence of the equilibrium state depends on an annual inflation adjustment equal to actual inflation. If that adjustment fails to keep pace with increases in input costs, the median will drop (in constant dollars) every year until only a small number of firms remains in the Medi-Cal program, assuming that there is some floor below which an operator cannot reduce average total costs. The existence of quality standards assures that there is such a floor.

Whether the state considers it desirable to continue to set rates at the median depends on the freedom of access to Medi-Cal beds it wishes to ensure. As the median shifts down forcing facilities from the market, the supply of beds will be reduced. The state's demand for beds may dictate that this downward trend in supply be stopped before equilibrium is reached. Therefore, when the supply reaches the level the state considers adequate, it should simply hold the rate constant (in constant dollars).

FOOTNOTES

1. Report of the Office of the Auditor General to the Joint Legislative Audit Committee, Long-Term Care for the Aged (Part One): An Overview and Medi-Cal Reimbursement for Skilled Nursing Care, January 1977, p. 14.
2. Ibid.
3. "This particular system of reimbursement which is called the EAV (equalized assessed valuation) system, was developed by the State in response to a need to have a system to reflect not only the costs being experienced, but to allow them to relate this to official value that had been set on the property itself, that is, in some manner to link this up to the official record of the county in which the facility was located." (Testimony of Jerome Hansen, "Medi-Cal Public Hearing," Volume 2, December 22, 1970, p. 17)
4. Interviews
5. California Ass'n. of Nursing Homes, etc. v. Williams App., 84 Cal. Rptr. 590, p. 599 (1970).
6. California Welfare and Institutions Code, div. 9, pt. 3, ch. 7, section 14104.
7. CANH v. Williams, p. 601.
8. Ibid., p. 599.
9. Ibid., p. 604.
10. "Middle Level State Nursing Care Planned," Los Angeles Times, 20 November 1970.
11. "Nursing Home Group Moves to Boycott Medi-Cal Patients," Los Angeles Times, 1 December 1970, part I, p. 1.
12. "Reagan Orders Medi-Cal Cuts, 10 Percent Reduction in Doctor's Fees," Los Angeles Times, 3 December 1970, part I, p. 1.
13. Robert Stevens and Rosemary Stevens, Welfare Medicine in America, (New York: The Free Press), 1974, p. 288.
14. "Nursing Home Group Moves to Boycott Medi-Cal Patients."
15. "Medi-Cal Cuts, Set to Start Today, Draw New Opposition," Los Angeles Times, 15 December 1970, part I, p. 1.
16. Ibid.

17. "Medi-Cal Nursing Home Patients to be Transferred to County Hospitals," Los Angeles Times, 30 January 1971, part II, p. 1.
18. "The State," Los Angeles Times, 31 March 1971, part I, p. 1.
19. Stevens and Stevens, p. 288.
20. "Compromise Ends Medi-Cal Dispute," Los Angeles Times, 30 March 1971, part I, p. 2.
21. Stevens and Stevens, p. 289.
22. Interviews.
23. Interviews. See also "California Association of Health Facilities Proposed Cost Related Reimbursement for Skilled Nursing and Intermediate Care Facilities; (xerox), in which CAHF proposes its ideal reimbursement system, a system which differs from the actual system only in that base rates are set at the 66 2/3 percentile of industry costs rather than at median cost, and there is an add-on for return on equity.
24. Assembly Bill No. 4242.
25. Assembly Bill No. 1427.
26. See "California Association of Health Facilities Position Paper for Rate Increase to Skilled Nursing and Intermediate Care Facilities Fiscal Year 1977-78," (xerox).
27. Rate Development and Review, Financial Operations Division, California Department of Health, "Study of Skilled Nursing Facility Costs," Report No. 01-77-3, p. 2.
28. Interview.
29. See California Association of Health Facilities, etc., v. Joseph A. Califano, Jr., etc., Complaint for Declaratory and Injunctive Relief, filed with the Clerk, U.S. District Court, Central District of California, July 14, 1978, para. 38d.
30. John Holahan and William Scanlon, "Medicaid: Current Issues and Potential Reforms," Urban Institute Working Paper No. 5057-4, March 1977, p. 16.
31. Interview.
32. Interview.
33. Interview.
34. See for example, Kenneth McCaffree, Sharon Winn, and Carl Bennett, "Final Report of Cost Data Reporting System for Nursing Home Care," Battelle Human Affairs Research Center, March 1977.

35. See for example, Paul Ginsberg, "Capital in Non-Profit Hospitals," unpublished Ph.D. Dissertation, Harvard University, 1970, and William J. Scanlon, "Aspects of the Nursing Home Market: Private Demand, Total Utilization and Investment," Urban Institute Working Paper No. 5907-1, February 1978.
36. Accountants for the Public Interest, "Financial Study of Skilled Nursing Facilities in San Francisco: 1974-1976," October 19, 1977, and, County of Los Angeles Nursing Home Task Force, Los Angeles County Nursing Home Study: 1975-1977.
37. Accountants for the Public Interest, p. 21.

APPENDIX A

Current Medi-Cal Nursing Home Reimbursement System

I. Cost Base

Rates for skilled nursing home care are determined annually by dividing SNFs into three classes by size (1-59 beds, 60-99 beds, 100 or more beds), adjusting each facility's reported costs as indicated below, and finding the median (i.e., the per diem costs of the 50th percentile facility in the array for each class.) Intermediate Care Facility rates for each size class are set at 80.5 percent of the corresponding SNF rate. New rates go into effect July 1 of each year and are based on cost reports covering each provider's last complete fiscal year as of the preceding December 31.

II. Adjustments to the BaseA. Audit Adjustment

Cost reports must be submitted within 90 days of the close of each provider's fiscal year. The state's audit capacity is insufficient to complete audits of facilities with fiscal year ends late in the calendar year before rates are determined in the spring. Consequently, the state calculates an audit deviation factor (average percentage charge between reported and audited costs among cost reports which are received earlier) and applies that percentage to the raw costs of the unaudited sample. (These reports are audited after the issuance of new rates in July and help determine the audit deviation factor in the following year).

Both field audit and desk audit deviation factors are computed. The excess of the field audit adjustment percentage over the desk review adjustment percentage is subtracted from the desk reviewed cost reports. Cost reports which have not been desk reviewed or field audited are adjusted by the average field audit percentage adjustment for the appropriate bed size class. The resulting costs are the base costs for rate determination.

B. Adjustment for Changes in Standards

Audited costs per patient day are adjusted to reflect the cost impact of state or federal legislation or regulations.

C. Inflation Adjustment

After adjustment as described in A and B above, costs are updated for inflation using the lesser of the California Consumer Price Index and recent historical cost trends. The CPI-based inflation factor is calculated by dividing the percent increase in the California CPI over the 24 month period ending on December 31 preceding the rate year by 24 to arrive at a monthly percent change. (This two year period is used so as to include every provider's entire reporting year.) An annual percent change (equal to 12 times this monthly percent change) is then compared with the index based on recent historical cost trends to determine which index will be used.

The index based on actual nursing home cost increases is determined by calculating the average across all providers of the percent change in each provider's allowable costs from the previous rate period to the current rate period. The lesser of the average of actual percent changes in costs and the CPI-based adjustment, serves as the basis for the inflation adjustment.

Because FY1979 rates were the first to be based on cost reports from all facilities, a comparison between costs reported for that rate year and the previous rate year was not possible. Therefore the inflation adjustment factor was based on the change in the CPI. This factor is applied by multiplying the number of months between the midpoint of the provider's reporting year and the midpoint of the rate year by the monthly CPI adjustment factor. The resulting percentage is applied to the provider's allowable costs. Rates are set at the median of facility costs so adjusted.

Use of historical cost trends in determining the inflation adjustment in future years is complicated by the difficulty in distinguishing between cost increases due to inflation and cost increases due to changes in nursing home regulations. The latter are to be excluded from the calculation of cost increases.

D. Minimum Rates

Rates for FY1979 shall not be less than the rates in effect on June 30, 1978.

III. Components of the Base

A. Allowable Costs

Allowable costs are determined in accordance with the principles of Medicare's Health Insurance Manual-15 (HIM-15).

B. Profit

No allowance for profit or return on equity is made.

CALIFORNIA ASS'N OF NURSING HOMES, ETC. v. WILLIAMS 593
 4 Cal.App.3d 806 Cite as, App., 84 Cal.Rptr. 500

4 Cal.App.3d 800

CALIFORNIA ASSOCIATION OF NURSING HOMES, SANITARIUMS, REST HOMES AND HOMES FOR THE AGED, INC., a California non-profit corporation, on behalf of a class of persons too numerous to mention, Plaintiff and Appellant,
 v.

Spencer W. WILLIAMS, Administrator of the Health and Welfare Agency of the State of California, Defendant and Respondent.

Civ. 12230.

Court of Appeal, Third District.

Feb. 24, 1970.

Rehearing Denied March 24, 1970.

See 85 Cal.Rptr. 735.

Hearing Denied April 29, 1970.

Wilke, Fleury, Sapunor & Hoffelt, by Richard H. Hoffelt, Sacramento, for plaintiff and appellant.

Thomas C. Lynch, Atty. Gen., by Walter J. Wiesner, Deputy Atty. Gen., Sacramento, for defendant and respondent.

FRIEDMAN, Associate Justice.

At issue in this appeal is the validity of an administrative regulation prescribing the standards which determine the level of state payments for the care of Medi-Cal

1. Under a gubernatorial reorganization plan of 1968 the Administrator's title was altered to Secretary of the Human Relations Agency and direct administrative responsibility for the Medi-Cal program transferred to the Director of Health Care Services. The transfer was confirmed by statute the following year. (Stats. 1969, ch. 21.) The transfer of responsibility does not negate this action. (Gov. Code, § 12090.7.) For convenience we shall refer to the currently responsible official, the Director of Health Care Services, as the respondent.

Press accounts indicate that Mr. Williams has resigned as Administrator of

patients in nursing and convalescent homes.

Petitioner is an association of state-licensed nursing and convalescent homes. At the commencement of this action respondent Spencer Williams held the office then entitled Administrator of the Health and Welfare Agency, now called Secretary of the Human Relations Agency. The Director of Health Care Services is the official currently directing the Medi-Cal program.¹ Petitioner filed this declaratory relief and mandamus action in the Sacramento Superior Court assailing validity of the regulation and contending that its financial provisions forced nursing homes to operate at a loss. After a hearing the court entered a judgment sustaining the regulation and declaring its validity. Petitioner appeals.

The basic features of the Medi-Cal program were described in some detail in *Morris v. Williams* (1967) 67 Cal.2d 733, 63 Cal.Rptr. 689, 433 P.2d 697. Suffice it to say here that Title XIX of the Social Security Act (Public Law 89-97, 79 Stat. 286, 1965) authorized federal financial support to states which adopted conforming medical assistance programs. The California Legislature responded with the enactment of legislation establishing the Medi-Cal program. (Stats. 2d Ex.Sess. 1965, ch. 4; Welf. & Inst. Code, div. 9, pt. 3, ch. 7.)² The new law became effective as an urgency measure on November 15, 1965, but expressly deferred operative date of the program until March 1, 1966.

the Health and Welfare Agency and has been succeeded by Mr. Lucian Vandegrift; also, that Mr. Carel Mulder, the current Director of Health Care Services, is about to retire. No attempt has been made to substitute parties respondent. We are about to remand this action to the superior court. Appropriate substitutions should be made prior to issuance of a writ of mandate.

2. Statutory references in this opinion will be to the Welfare and Institutions Code unless otherwise specified.

As presently framed, the Medi-Cal legislation reposes administrative responsibility in the Director and Department of Health Care Services (§§ 14061-14062). It authorizes a variety of health care services for the needy, including nursing home services. (§ 14053.) One provision (§ 14104 as last amended by Stats.1969, ch. 880) directs the department "to the extent feasible" to contract with carriers for the rendition of health services through health benefit plans. The same provision expresses a formula for establishing payment rates to the providers of health services.³ Another provision (§ 14105, as last amended by Stats.1969, ch. 1274) authorizes the Director to "limit the rates of payment for such services" and to adopt rules and regulations, including those which fix rates of payment for services not rendered under contract with carriers.⁴

Inasmuch as sections 14104 and 14105 call for regulations covering rates of payment for health services, the issues will be better viewed in the light of the Government Code provisions establishing procedures for the adoption of regulations. With inapplicable exceptions, regulations adopted by state agencies must be filed with the Secretary of State and published in the California Administrative Code. (Gov.Code, §§ 11380, 11409.) "Basic minimum procedural requirements" for the adoption or amendment of regulations call

upon the agency to publish and mail notice of its proposed action, to provide interested persons an opportunity for hearing and to give consideration to all relevant matter presented to it. (Gov.Code, §§ 11420, 11423, 11424, 11425.) The demand for prior notice and hearing does not apply to the adoption of an emergency regulation which is accompanied by a statement of facts constituting the emergency; an emergency regulation, however, becomes ineffective at the end of 120 days unless within that time the agency certifies that it has provided notices and an opportunity for hearing. (Gov.Code, §§ 11421, 11422.1.) Regulations ordinarily become effective 30 days after filing, but an emergency regulation may be made effective immediately. (Gov.Code, § 11422.) Any interested person may petition a state agency requesting the adoption or repeal of a regulation. (Gov.Code, § 11426.) Any interested person may obtain a judicial declaration as to the validity of a regulation in a declaratory relief action; in addition to any other ground of invalidity, the judgment may declare the regulation invalid for substantial violation of the procedural statutes or, in the case of an emergency regulation, upon the ground that the facts in the accompanying statement do not constitute an emergency. (Gov.Code, § 1440.)

The challenged regulation is section 51511 of title 22, California Administrative

3. At this point section 14104 states: "Payment for services to hospitals and other facilities and professional services shall be predicated on the basis of reimbursement for reasonable cost based on standards, determined by the director with the advice of the Health Review and Program Council. The formula for such payments shall be determined in accordance with regulations establishing the methods to be used and the items to be included. In prescribing such regulations, the department shall consider, among other things, the principles generally applied by state organizations representing such hospitals or other facilities or by established prepayment organizations which have developed such principles, in determining the method or methods to be used in arriving at the payment formula."

4. Section 14105 states: "The director shall prescribe the policies to be followed in the administration of this chapter and the scope of the services to be provided, and may limit the rates of payment for such services, and shall adopt such rules and regulations as are necessary for carrying out, not inconsistent with, the provisions thereof."

"Such policies and regulations shall include rates for payment for services not rendered under a contract pursuant to Section 14104. Standards for costs shall be based on payments of the reasonable cost for such services. * * *" (The italicized clause was added by a 1967 amendment.)

CALIFORNIA ASS'N OF NURSING HOMES, ETC. v. WILLIAMS

595

4 Cal.App.3d 809

Cite as: App., 84 Cal. Rptr. 500

Code. Since its original adoption in June 1966 it has been amended five times, the current regulation representing its sixth version. The original regulation and all later mutations were purportedly adopted as "emergency" regulations. For present purposes it will be adequate to set out in the margin the version in effect at the time this lawsuit was commenced, the amendment filed on June 8, 1967.⁵

Aside from the fixed ceiling on per diem payments, the challenged regulation does not on its face establish a standard for reimbursing nursing and convalescent homes. Rather, it incorporates by reference the contents of a statement or document entitled "State Schedule of Maximum Allowances, Section II, Part C, Long-Term Care Facilities." The Schedule of Maximum Allowances appears nowhere in the California Administrative Code. It takes the form of a pamphlet published by the State Department of Finance, bearing the issue date of February 1, 1967, but declaring an effective date of July 1, 1966. By fixing reimbursement in accordance with the Schedule of Maximum Allowances in effect at the time services are provided, Regulation 51511 evidences a design to incorporate future changes in reimbursement standards adopted by the Department of Finance. Pending this appeal, the Department issued a new version of the Schedule

of Maximum Allowances dated August 1, 1969.

In summary, the Schedule of Maximum Allowances issued by the Department of Finance declares its application to all medical care and rehabilitation programs operated by the state, with certain exceptions of no moment here. It provides for fixed levels of payment according to a schedule of specified rates or, alternatively, an individualized rate as shown by costs statements submitted by the particular nursing home. The individualized rate is determined by compounding two kinds of costs: *departmental*, i. e., primarily administrative and operating expenses, and *nondepartmental*, i. e., taxes, insurance and capital-related costs. Actual departmental costs are limited by three factors: (a) an assumed bed occupancy level of 90%, (b) administrative costs not exceeding 15% of operating costs, and (c) a scale of departmental cost ceilings, expressed in fixed dollar amounts and varying with the number of beds in the facility.⁶ Nondepartmental costs are fixed by an artificial formula roughly amounting to 18% of the facility's equalized assessed value (as shown on the county tax rolls) per bed per day.

The daily rate established by the rate schedule or the combination of the particular facility's departmental and nondepartmental costs as provided in the Schedule of

5. Title 22, section 51511, provided: "Effective July 1, 1966, reimbursement to nursing and convalescent homes shall be made in accordance with the State Schedule of Maximum Allowances, Section II, Part C, Long-Term Care Facilities which is in effect at the time medical assistance is provided.

"(a) The per diem rate paid under this section shall not exceed \$12.74, excepting that the Administrator may negotiate all-inclusive per diem rates which provide for additional medically indicated covered service and provided that such negotiated rates do not increase overall program costs.

(b) A facility may continue until June 30, 1967, the per diem rate in effect during April, 1967, with the approval of the Administrator."

A later version of the regulation, filed as an "emergency" amendment on Febru-

ary 9, 1968, increased the daily rate ceiling from \$12.74 to \$14.

6. In the Schedule of Maximum Allowances issued by the Department of Finance on February 1, 1967, the ceiling on departmental costs per "bed day" ranged from \$10.28 for 43-bed or smaller facilities down to \$9.05 for 127-bed or larger facilities. In a reissue of the Schedule of Maximum Allowances dated August 1, 1969, the ceilings range from \$11.54 in smaller facilities down to \$10.25 in larger facilities. As explained infra, these changes were not promulgated through publicly noticed hearings on the part of the Medi-Cal agency but were imposed by decisions made within the State Department of Finance without compliance with the Government Code's demands for public participation in the determinative process.

Maximum Allowances is, in turn, subject to the \$14 ceiling presently fixed by Regulation 51511 (fn. 5, *supra*).

Before bringing suit, petitioner resorted to the administrative remedy provided by Government Code, section 11426, filing an administrative petition which alleged that Regulation 51511 resulted in per diem payments less than the nursing homes' reasonable cost per patient and requesting a public hearing and amendment of the regulation. An administrative hearing was held on October 20, 1967. At the hearing petitioner and another party presented oral testimony and an extensive set of documentary exhibits. The Health and Welfare Agency presented no evidence either to support its existing regulation or to rebut the showing of the complainants. It did not expressly reject the petition nor did it take action to amend the existing regulation. This suit was filed on January 23, 1968.⁷

In the trial court and in their original briefs on appeal, the parties raised three basic issues: (1) whether Regulation 51511 violates the statutory mandate requiring reimbursement for health services at rates based on reasonable costs; (2) whether, like public utilities, nursing and convalescent homes are constitutionally entitled to rates supplying a reasonable financial return on their investments; (3) whether, assuming invalidity of the administratively fixed reimbursement standard, the nursing and convalescent homes are entitled to reimbursement at a higher rate applied retroactively to March 1, 1966, the commencement of the Medi-Cal program.

Preliminary inquiry led this court to believe that the appeal might turn on sufficiency of the Medi-Cal agency's administrative procedures, that is, that the trial court might have erred in sustaining Regulation 51511 in the face of an administrative record which prevented meaningful judicial review. We requested and received supplemental briefs on this and allied questions. ¹ We have concluded that the adoption and repeated amendment of the regulation are characterized by serious procedural vices which prevent meaningful judicial review and frustrate any attempt to pass upon its substantive compliance with the "reasonable cost" standard.

Propriety of Regulation Adoption Procedure

[1,2] California decisions on judicial review of administrative regulations reveal three kinds of inquiry: first, whether the agency has statutory authority to adopt a regulation of the kind under scrutiny; second, whether the action is arbitrary or entirely lacking in evidentiary support; third, whether the agency has complied with statutory procedures.⁸ The agency's action comes before the court with a presumption of correctness and regularity, which places the burden of demonstrating invalidity upon the assailant.⁹

[3] Petitioner's principal complaint has been the regulation's alleged violation of the statutory standard for reimbursement based upon the "reasonable cost" of the services. (§§ 14104, 14105, fns. 3, 4, *supra*.) Essentially, such a claim is one of

7. Although the Health and Welfare Agency did not expressly reject the request for amendment, the Attorney General does not claim that petitioner failed to exhaust its administrative remedies. During the pendency of this action, Regulation 51511 was twice amended without recognizing petitioner's contentions. In effect, the administrative agency has rejected these contentions. (See *Hollon v. Pierce* (1967) 257 Cal.App.2d 468, 476, 64 Cal.Rptr. 808.)

8. *Morris v. Williams*, *supra*, 67 Cal.2d at pp. 748-749, 63 Cal.Rptr. 689, 433 P.2d 697; *Pitts v. Perlman* (1962) 58 Cal.2d 824, 832, 27 Cal.Rptr. 19, 377 P.2d 83; *Rivera v. Division of Industrial Welfare* (1968) 265 Cal.App.2d 576, 594, 71 Cal.Rptr. 739.

9. Evidence Code, section 664; *Ralphs Grocery Co. v. Reimel* (1968) 69 Cal.2d 172, 175, 70 Cal.Rptr. 407, 444 P.2d 79; *Rivera v. Division of Industrial Welfare*, *supra*, 265 Cal.App.2d at p. 594, 71 Cal.Rptr. 739.

arbitrariness, an entire lack of evidentiary support.¹⁰ In this case the reviewing court has no means of evaluating the complaint because the agency has not compiled an identifiable body of evidence by which to measure the regulation's compliance with the statutory standard.

[4] A statute calling for the adoption of administrative orders upon public notice and hearing implies that the evidence supporting the order be disclosed and made part of a hearing record with opportunity for refutation.¹¹ In *Rivers v. Division of Industrial Welfare*, supra, 265 Cal.App.2d 576, 71 Cal.Rptr. 739, at p. 751, this court observed that statutory demands "for noticed and recorded hearings are designed to insure fairness and inhibit arbitrariness through the instrumentalities of public participation in the investigative activity and a record paving the way for judicial re-

view. Such assurances cannot be fulfilled by recorded hearings which are paralleled by substantial 'off-record' investigations."

[5] Generally, an administrative agency, directed to fix rates or price levels after a hearing, may not base its decision upon evidence outside the record and not made available for rebuttal by the affected parties.¹² In part the demand is implied from statutes calling for public hearings as an assurance of fairness. In part it derives from the obvious need for an administrative record in the case of effective judicial review.¹³ In some cases effective review entails examination of the administrative findings in order to test the legal principles employed by the agency and to discern the sufficiency of the evidence.¹⁴ In other cases the need is for the transcribed oral testimony and the documentary exhibits.¹⁵

10. "An action is arbitrary when it is based on no more than the will or desire of the decision-maker and not supported by a fair or substantial reason (*Belford Inv. Co. v. Folb* (1947) 79 Cal.App.2d 333, 306, 180 P.2d 361; *State ex rel. Cosmopolis Consol. School Dist. No. 99, Grays Harbor County v. Bruno* (1963) 61 Wash.2d 461, 378 P.2d 691, 696; see Jaffe, *Judicial Review: Question of Fact*, 159 Harv.L.Rev. 1020, 1021 (1956))." (*Clack v. State of California*, 275 A.C.A. 843, 847, 80 Cal.Rptr. 274, 276.)

11. *Morgan v. United States* (1937) 304 U.S. 1, 14-15, 18-19, 58 S.Ct. 773, 82 L.Ed. 1129; *Morgan v. United States* (1936) 298 U.S. 463, 470-481, 56 S.Ct. 908, 80 L.Ed. 1288; *Interstate Commerce Com. v. Louisville & N. R. Co.* (1912) 227 U.S. 88, 91, 33 S.Ct. 185, 57 L.Ed. 431; *Olive Proration etc. Com. v. Agric. etc. Com.* (1941) 17 Cal.2d 204, 210, 109 P.2d 918; *Rivers v. Division of Industrial Welfare*, supra, 265 Cal.App.2d 576, 71 Cal.Rptr. 739; *United Air Lines v. Industrial Welfare Com.* (1963) 211 Cal.App.2d 729, 754, 28 Cal.Rptr. 238.

12. *Morgan v. United States*, supra, 298 U.S. at pp. 470-481, 56 S.Ct. 906, 80 L.Ed. 1288; *Olive Proration etc. Com. v. Agric. etc. Com.*, supra, 17 Cal.2d at p. 210, 109 P.2d 918; *Rivers v. Division of Industrial Welfare*, supra, 265 Cal.App.2d at pp. 548-549, 71 Cal.Rptr. 739; see also cases cited 18 A.L.R.2d 552, 589, fns. 10-19, inclusive.

13. In the review of administrative adjudications in California, Code of Civil Procedure, section 1094.5, expressly provides for transmission of the evidentiary record to the court. That statute does not govern judicial review of administrative rule-making. (*Brock v. Superior Court* (1952) 100 Cal.App.2d 594, 598, 241 P.2d 283.) In the latter kind of review the demand for an administrative record is implied rather than expressed. As the writer of the *Brock* opinion pointed out (100 Cal.App.2d at p. 608, 241 P.2d at p. 292): "How can an abuse of discretion be determined other than by an examination of the record on which the action was taken?"

14. *United States v. Chicago M. St. P. & P. R. Co.* (1935) 294 U.S. 489, 504-505, 55 S.Ct. 462, 79 L.Ed. 1023; *California Motor Transport Co. v. Public Utilities Com.* (1963) 59 Cal.2d 270, 273-275, 28 Cal.Rptr. 868, 379 P.2d 324; *County of Amador v. State Bd. of Equal.* (1966) 240 Cal.App.2d 205, 216, 49 Cal.Rptr. 448; see *Chicago & E. I. R. Co. v. United States* (1963) 375 U.S. 150, 84 S.Ct. 224, 11 L.Ed.2d 217, separate opinion of Black, J.; 2 Davis, *Administrative Law Treatise* (1958) §§ 16.01, 16.05.

15. *Ray v. Parker* (1940) 15 Cal.2d 275, 303-310, 101 P.2d 665; *Brock v. Superior Court*, supra, 100 Cal.App.2d at pp. 602-608, 241 P.2d 283.

As succinctly as possible, *United States v. Chicago, M., St. P. & P. R. Co.*, supra, 294 U.S. at page 511, 55 S.Ct. at p. 467, states why an administrative record is the *sine qua non* of judicial review: "We must know what a decision means before the duty becomes ours to say whether it is right or wrong."

In promulgating the regulations directed by the Medi-Cal legislation, the administrator was bound by the Government Code provisions fixing "basic minimum procedural requirements" for the adoption and amendment of administrative regulations. (Gov.Code, § 11420.) Ordinarily, these call for published and mailed notices and a hearing at which any interested person may present statements, arguments or contentions; for the administration of an oath in the event oral testimony is taken; for the agency's consideration of all relevant matter presented to it. (Gov.Code, §§ 11423-11425.) These and the companion provision for judicial review (Gov.Code, § 11440) rest upon the assumption that a body of relevant evidentiary material will be compiled at the hearing, considered by the agency in formulating its order, preserved by it and transmitted to the court for the latter's use when and if review is sought. That assumption is unfulfilled here.

[6] The record on appeal and the briefs of counsel point to no assemblage of evidence upon which the agency based its regulation. In the brief span of 30 months

—from the regulation's original adoption in June 1966 through its fifth amendment in January, 1969—the enacting agency invoked the emergency adoption procedure six times. Possibly these "emergencies" were viewed as occasion for dispensing with the establishment of a supporting evidentiary record.¹⁶ On the assumption that the regulation's adoption and five later amendments were accompanied by hearings, the nature of these hearings remains unrevealed. Neither in the superior court nor on appeal has the Medi-Cal administrator declared whether such hearings were held; what, if anything, happened at these hearings; what, if any, evidence, was offered or accepted as the basis for its determination of "reasonable costs." The presumption of regularity cannot supply the lack of a hearing. (*Interstate Comm. Com. v. Louisville etc. R. Co.*, supra, 227 U.S. at pp. 93-94, 33 S.Ct. 185, 57 L.Ed. 431.)

In response to this court's specific inquiry, the Attorney General has conceded that the Medi-Cal administrator "did not create a formal administrative record containing the evidence upon which he relied in adopting the regulation." He argues, nevertheless, that there was substantial compliance with procedural demands, because petitioner and its members were party to rate negotiations with the agency's staff and had copies of federal and state publications, as well as reports of private hospital associations and similar groups, which played a role in these negotiations.

16. The unbroken succession of "emergencies" suggests that some of the occasions were less exigent than others. Several of the descriptions of urgency are nothing more than statements of the motivation for the amendment. Concerning the genuineness of other emergencies there is little doubt. The wrinkles which frequently characterize new-born governmental programs were here magnified into chasms and mountains by inadequate legislative timetables and overlapping legislative mandates. The Medi-Cal legislation became effective November 15, 1965, with a direction that the program go into operation 3½ months later, on March 1,

1966. In that narrow span the Administrator of the Health and Welfare Agency faced the monumental tasks of assembling an operating staff, coalescing treatment and healing facilities into a functioning statewide program, coordinating state and county activities, establishing treatment and financial standards and providing claims-receiving, review and disbursement machinery. The administrative convulsions accompanying the birth of the Medi-Cal program in 1965-1966 have been documented in the press and are a matter of common public knowledge.

[7,8] Administrative agencies have wide latitude in fashioning procedures and pursuing their methods of inquiry. (Federal C. C. v. Pottsville Broadcasting Co. (1940) 309 U.S. 134, 143, 60 S.Ct. 437, 84 L.Ed. 656.) Procedural elasticity cannot be stretched into disregard of the law's public hearing demand. Private negotiations with selected members or representatives of an affected industry are no substitute for public hearings. There is a public interest in having the law obeyed. Directed by law to hold public hearings, government officials may not resort to invitational gatherings with selected members of an affected business. The participating firms and associations, however immediately affected, cannot waive the public's right of participation. Moreover, the assemblage of an amorphous mass of documents or reports utterly fails to identify the evidence which the Medi-Cal administrator considered and that which he did not. For all that appears here, he may have ignored the collection of documents and reports later placed in evidence in the trial court. In a curious inversion of roles, the assailant of the regulation, not its proponent, has presented the only evidence by which to measure its substantive validity. The administering agency has never revealed an evidentiary basis for its action. The claim of substantial compliance is untenable.¹⁷

17. Neither party has discussed the provision of section 14104 (fn. 3. *supra*) which obliges the director to determine rate standards with the advice of the Health Review and Program Council. The record reveals neither compliance nor violation of this obligation.

18. At this point the comment of Chief Justice Hughes in *Morgan v. United States*, *supra*, 298 U.S. at page 481, 56 S.Ct. at p. 911, 80 L.Ed. 1288, is remarkably apropos: "There is thus no basis for the contention that the [statutory] authority . . . is given . . . so that one official may examine evidence, and another official who has not considered the evidence may make the findings and order. In such a view, it would be possible, for example, for one official to hear the evidence and argument and arrive at certain conclusions of fact, and another

[9] The administrator's failure to assemble an evidentiary record is compounded by his attempt to incorporate by reference the publication of the State Department of Finance known as the Schedule of Maximum Allowances. The administrator asserts that his rate-fixing power includes authority to adopt the standards developed by the state fiscal agency. The assertion does not respond to statutory procedural demands for a public hearing at which evidence to support the proposed regulation is received, made available for rebuttal, weighed and considered by the law's designated agent and compiled in an identifiable record as the basis for judicial review. The Schedule of Maximum Allowances appears to be the result of *ex parte* studies by staff personnel of the Department of Finance. The Attorney General is frank in stating: "Insofar as the establishment of maximums [i. e., rate ceilings] are concerned, this was action taken by the Director of Finance." To put the matter bluntly, Regulation 51511 is the product of the Department of Finance, not of the Medi-Cal agency. The latter's adoption of the former's fiat without independent consideration of the underlying evidence and without public or judicial access to it transgresses fundamental demands for the adoption of administrative regulations.¹⁸

Compliance with the public hearing demand precludes promulgation in the inner

official who had not heard or considered either evidence or argument to overrule those conclusions and for reasons of policy to announce entirely different ones. It is no answer to say that the question for the court is whether the evidence supports the findings and the findings support the order. For the weight ascribed by the law to the findings—their conclusiveness when made within the sphere of the authority conferred—rests upon the assumption that the officer who makes the findings has addressed himself to the evidence and upon that evidence has conscientiously reached the conclusions which he deems it to justify. That duty cannot be performed by one who has not considered evidence or argument. It is not an impersonal obligation. It is a duty akin to that of a judge. The one who decides must hear."

chambers of government offices, whether of the administering or fiscal agency. In *Olive Proration etc. Com. v. Agric. etc. Com.*, supra, the agency completed its hearings and then, without notice to the parties, received and considered a field survey and report made by the Department of Finance. The court invalidated the procedure, declaring (17 Cal.2d at p. 210, 109 P.2d at p. 921): "The parties were not apprised that this survey was being made or of the result of it until after the last order of the commission was promulgated. As a result they were denied all right of cross-examination with respect thereto and also of an opportunity to make a counter showing in rebuttal. Under such circumstances, the statutory requirement of a hearing was not met. [Citations.] Only evidence which the opposite party has an opportunity to refute at the hearing may be relied upon as the basis of a finding. [Citation.]"

[10] There is no procedural barrier prohibiting the enacting agency from adopting by reference a set of standards issued by another agency if supporting evidence is made available at a public hearing, opportunity for refutation is given, the pro and con evidence considered and the evidentiary material assembled in an identifiable record. On the other hand, an attempt to embody by reference future modifications of the incorporated material without additional hearings would have dubious validity. (See *Olive Proration etc. Com. v. Agric. etc. Com.*, supra, 17 Cal.2d at p. 209, 109 P.2d 918.)

[11] The state's appropriation for administrative expenses of the Medi-Cal program during the 1966-1967 fiscal year was accompanied by the following legislative declaration: "* * * provided, that any rule or regulation adopted by the Health and Welfare Agency Administrator during the 1966-67 fiscal year which adds to the cost of the medical assistance program shall only be effective from and after the date upon which it is approved as to availability of funds by the Department of Finance." (Stats.1966, 2d Ex.Sess., ch. 2, item 161.5.) A similar proviso has been

attached to the annual appropriation for each of the subsequent fiscal years. (Stats.1967, ch. 500, item 120; Stats.1968, ch. 430, item 124; Stats.1969, ch. 355, item 141.)

Contrary to the administrator's contention, these provisos do not authorize the Department of Finance to adopt supervening regulations establishing rates for health care services; nor do they permit the Director of Health Care Services to incorporate the promulgations of the Department of Finance without compliance with the public hearing process. The Medi-Cal legislation, in sections 14104 and 14105, enjoins the Director of Health Care Services, no one else, to adopt regulations establishing these rates. In the enactment of these regulations he, no one else, is to receive and consider the evidence which will permit compliance with the statutory standard of "reasonable cost." The provisos attached to the annual appropriations empower the Department of Finance to defer the effective date of a rate-fixing regulation pushing current expenditures above available funds. Beyond authorizing postponement, they do not repose conflicting or overriding power in the fiscal agency.

Recognizing the procedural deficiencies which characterize the promulgation process, the petitioner nursing homes nevertheless maintain their claim that Regulation 51511 fails to meet the statutory standard of "reasonable cost." They call our attention to the set of 61 documentary exhibits which they—not the Medi-Cal agency—introduced at the administrative hearing held in response to their petition. The same 61 exhibits were introduced in the superior court by stipulation. The nursing homes urge us to measure the substantive validity of the regulation, including the Schedule of Maximum Allowances, against this assemblage of evidence.

[12] That kind of action would overstep the judicial function by a wide margin. The function is quite restricted. "As to the quasi-legislative acts of administrative agencies, 'judicial review is limited to an examination of the proceedings before

CALIFORNIA ASS'N OF NURSING HOMES, ETC. v. WILLIAMS

601

4 Cal.App.3d 817

Cite as: App., 84 Cal.Rptr. 509

the officer to determine whether his action has been arbitrary, capricious, or entirely lacking in evidentiary support, or whether he has failed to follow the procedure and give the notices required by law." (Pitts v. Perluss, *supra*, 58 Cal.2d at p. 833, 27 Cal.Rptr. at 24, 377 P.2d at 88, quoting from Brock v. Superior Court, *supra*, 109 Cal.App.2d at p. 605, 241 P.2d 283; see also Rivera v. Division of Industrial Welfare, *supra*, 265 Cal.App.2d at p. 594, 71 Cal.Rptr. 739.) Without identification of the evidence forming the basis of the agency's action, a reviewing court can neither affirm nor deny the existence of evidentiary support.¹⁹ The court cannot invalidate the action by measuring evidence produced by its assailant, for it may differ from the evidence considered by the administrator. Without a record identifying the latter, the deficiency centers on the promulgation process, never reaching the alleged substantive violation.

[13] The failure of the Medi-Cal administrator to hold hearings establishing an evidentiary record underlying Regulation 51511 thwarts judicial review of the regu-

lation's compliance with the "reasonable cost" standard and constitutes a substantial failure to comply with the procedural demands of the Administrative Procedure Act. It follows that the current regulation and its predecessors are invalid.²⁰ The administrator has as yet failed to comply with the statutory mandate to adopt a regulation establishing rates of payment for nursing home services. We next consider the effect of that failure.

Retroactive Entitlement and Payment for Past Services.

[14, 15] The nursing homes claim entitlement to a retroactive regulation establishing rates covering all services since the program's inception on March 1, 1966. One theory underlying this claim is constitutional. Petitioner points out that the advent of publicly financed medical care has impelled a huge increase in the number and capacity of proprietary nursing homes, simultaneously making them economically dependent on publicly assisted patients and on the state's business.²¹ Charging economic compulsion, petitioner compares its

19. While the opportunity for *de novo* consideration at the judicial review stage may satisfy the needs of constitutional due process, it does not cure administrative noncompliance with statutes demanding public participation in the promulgation process. (See 1 Davis, *Administrative Law Treatise* (1958) § 7.10.) One court has observed: "This provision [for judicial review] did not obviate the necessity of a proper, legal hearing before the commission. It [the legislature] did not contemplate that the failure of the commission to hold a proper hearing should be corrected by appeal." (*L. A. Darling Co. v. Water Resources Com.* (1965) 341 Mich. 654, 665, 67 N.W. 2d 890, 896.)

20. Government Code, section 11440, a provision of the Administrative Procedure Act, declares: "Any interested person may obtain a judicial declaration as to the validity of any regulation by bringing an action for declaratory relief in the superior court in accordance with the provisions of the Code of Civil Procedure and in addition to any other

ground which may exist, such regulation may be declared to be invalid for a substantial failure to comply with the provisions of this chapter or, in the case of an emergency regulation or order of repeal upon the ground that the facts recited in the statement do not constitute an emergency within the provisions of Section 11421(b).

21. See Report, *Impact of Federal and State Medical Assistance Programs on Nursing Homes* (State of California, Health and Welfare Agency, Office of Health Care Services (1967) pp. 2-3, 19-20.) The nursing homes call our attention to a stipulation between themselves and the Medi-Cal agency in a related superior court action, in which the parties stipulated to the existence of approximately 80,000 beds in licensed nursing homes in California. Of these, 8,000 were vacant. Of the 72,000 remaining beds, 65 percent were occupied by Medi-Cal patients, 25 percent by Medicare and 10 percent by private patients. The Director of Health Care Services does not gainsay these figures.

members with public utilities, which are constitutionally entitled to service rates which are just and reasonable from an investor's standpoint. (See *Federal Power Com. v. Hope Natural Gas Co.* (1944) 320 U.S. 591, 603, 64 S.Ct. 281, 88 L.Ed. 333.) Thus petitioner deduces a constitutional demand for a rate structure supplying both operating expenses and a reasonable return on invested capital. It protests the concept which, it claims, has colored the position of the Medi-Cal administrator, that of historic cost without any provision for retroactive adjustment to meet actual cost. It points out that the actual costs of private nursing home care (including a return on risk capital) vary widely. Petitioner contends that "reasonable cost" cannot be artificially pegged at a level below actual cost.

The public utility analogy fails. Unlike public utilities, nursing homes are under no legal compulsion to serve all customers. If they are under economic pressure to accept state business, it is because they undertook the risks of a business burdened with that characteristic. Government is under no constitutional mandate to eliminate the economic perils involved in doing business with it. The Medi-Cal program seeks to subsidize needy patients, not to insulate suppliers from business risks. Here the state is not regulating the rate which the entrepreneur may charge his customers; rather, it is fixing the price it is willing to pay as one of the customers, albeit the largest. Legal compulsion to accept all state-supported patients might indeed evoke a "constitutional right." (See *United States v. New York Central R. Co.* (1929) 279 U.S. 73, 78, 49 S.Ct. 260, 73 L.Ed. 619.) There is no such compulsion here. The law gives nursing homes liberty to price themselves out of the Medi-Cal market, as some (so the Attorney General informs us) have done.

[16] An alternative theory for the claim of retroactive entitlement is contractual. A statute fixing government pay-

ments may amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree. (*County of San Luis Obispo v. Gage* (1903) 139 Cal. 398, 406-407, 73 P. 174.)

[17] Sections 14104 and 14105 (fns. 3 and 4, *supra*) do not express a statutory offer. They fix no scale of payment, but only a standard, i.e., reasonable cost, for an administrative regulation fixing a rate or rate formula. Despite the standard's verbal simplicity, its expression in a regulation involves "highly technical matters requiring the assistance of skilled and trained experts and economists and the gathering and study of large amounts of statistical data and information." (*Pitts v. Perluss*, *supra*, 58 Cal.2d at p. 835, 27 Cal.Rptr. at p. 25, 377 P.2d at p. 89.) To say that an increased rate is reasonable does not mean that the rate preceding it was unreasonable. The reasonable cost standard allows so many variables that administrative implementation is indispensable to the creation of financial claims in specific amounts. The statutes do not amount to an offer in the contractual sense.

[18] Despite rejection of constitutional and contractual theories of entitlement, the nursing homes have a right to have the statute obeyed. The Medi-Cal legislation calls for a regulation establishing rates or a rate formula for nursing home care. Such a regulation does not now exist. The Director of Health Care Services is now obliged to adopt one. The nursing homes are entitled to a writ of mandate compelling him to perform this duty as one enjoined upon him by law. (*County of Los Angeles v. Riley* (1942) 20 Cal.2d 652, 662, 128 P. 2d 537.)

[19,20] At that point a very practical problem arises, that of establishing rates or a rate formula retroactively covering services back to the March 1, 1966, inception

CALIFORNIA ASS'N OF NURSING HOMES, ETC. v. WILLIAMS

603

4 Cal.App.3d 819

Cite as: App., 84 Cal. Rptr. 580

date. The invalid orders of the past do not estop the director after the remand or control him in reconsidering the entire problem in the light of all the information available to him. (St. Joseph Stock Yards Co. v. United States (1936) 298 U.S. 38, 63-64, 56 S.Ct. 720, 80 L.Ed. 1033; Delta Air Lines, Inc. v. Civil Aeronautics Board (1960) 108 U.S.App.D.C. 88, 280 F.2d 636, 639; see 2 Davis, Administrative Law Treatise, § 18.08, pp. 598-599.) On review the courts may correct his error of law and on remand he is bound to enforce the legislative policy committed to his charge. (Federal C. C. v. Pottsville Broadcasting Co., supra, 309 U.S. at pp. 145-146, 60 S. Ct. 437, 84 L.Ed. 656.)

Aside from the one-time power to correct his invalid action, there is the question of the director's standing authority to adopt regulations permitting retroactive redeterminations. That question is not directly posed here. In fashioning administrative solutions, the parties may find useful advice in the mail rate cases. The analogy seems more apt than the public utility decisions. In the mail rate cases, as here, the administrator fixes rates under statutory direction for a service purchased by the government as a customer. (See Transcontinental and W. Air, Inc. v. Civil Aeronautics Bd. (1949) 336 U.S. 601, 605-606, 69 S.Ct. 756, 93 L.Ed. 911, also separate opinion of Jackson, J., at p. 608, 69 S. Ct. 756; United States v. New York Central R. Co., supra, 279 U.S. at p. 77, 49 S. Ct. 260; Trans World Airlines, Inc. v. Civil Aeronautics Bd. (1967) 128 U.S. App.D.C. 126, 385 F.2d 648, 658; American Overseas Airlines, Inc. v. Civil Aeronautics Bd. (1958) 103 U.S.App.D.C. 41, 254 F.2d 744, 749-750; cf. Pacific Tel. & Tel. Co. v. Public Util. Com. (1965) 62 Cal.2d 634, 650-653, 44 Cal.Rptr. 1, 401 P. 2d 353; see also, 1 Davis, Administrative Law Treatise, § 7.08.)

Our attention has also been called to a memorandum opinion, dated December 8, 1969, by a three-judge federal court in the

case of Catholic Med. Center of Brooklyn & Queens Inc. v. Rockefeller (U.S. Dist. Ct., Eastern Dist. N.Y., No. 69-C-641) 305 F.Supp. 1268. The opinion deals with a regulation of the federal Department of Health, Education and Welfare under Title XIX of the Social Security Act, requiring provision for retroactive adjustments in rates of hospital payment.

Petitioner seeks to have rates for past and future care measured by the reasonable cost yardstick, free or virtually free of fiscal restrictions. The statutes, to the contrary, bespeak a legislative response not only to medical needs and the quality of medical care, but also to the promptings of fiscal economy. At least three separate sources express meaningful financial limitations. These financial limitations, springing from sources outside the Medi-Cal law itself, are entitled to concurrent operation with it. (See Morris v. Williams, supra, 67 Cal.2d at p. 752, 63 Cal. Rptr. 689, 433 P.2d 697; Warne v. Harkness (1963) 60 Cal.2d 579, 588, 35 Cal.Rptr. 601, 387 P.2d 377.)

In the first place, all actions of the Medi-Cal administrator are limited by the annual appropriations for health services. (Morris v. Williams, supra, 67 Cal.2d at pp. 749-750, 63 Cal.Rptr. 689, 433 P.2d 697.) Secondly, a 1967 amendment to section 14105 added a clause authorizing the director to "limit the rates of payment" for services. (See fn. 4, supra.) There is no need to decide here whether the 1967 amendment extracts any vital ingredient from the reasonable cost standard. Suffice it to say that it manifests a legislative intent to compromise reimbursement rates if necessitated by fiscal limitations. (Morris v. Williams, supra, 67 Cal.2d at pp. 757-758, 63 Cal.Rptr. 689, 433 P.2d 697.)

The provisos attached to the annual Budget Act appropriations for the administrative expense of the Medi-Cal program form a third limitation. These provisos, as noted earlier, declare that "any rule or

regulation adopted by the Director of the Department of Health Care Services during the [specified] fiscal year which adds to the cost of the medical assistance program shall only be effective from and after the date upon which it is approved as to availability of funds by the Department of Finance."

[21] As we stated above, these provisos authorize the Department of Finance to demand deferment, but not to establish overriding or conflicting rates. Petitioner argues that this clause arms the Department of Finance with no power over nursing home rates, being attached to the appropriations for administrative costs, not the appropriations for health costs. To the contrary, ¹⁸²⁰ it evokes the fiscal agency's deferment authority as to any regulation increasing costs of the *program*. It is broader than a restriction on administrative expense. Health service cost (including nursing home care) is the prime ingredient of program cost. Hence a regulation allowing increased nursing home rates cannot be effective until the fiscal agency approves it from the standpoint of fund availability. The limitation extends equally to a regulation fixing current rates and one applicable to the past.

Order

The judgment is reversed and the cause remanded to the superior court with directions to issue a peremptory writ of mandate ordering the Director of Health Care Services to adopt a regulation or regulations establishing rates or rate formulae for the care of Medi-Cal patients in nursing and convalescent homes and, in the promulgation thereof, to give public notice and hold public hearings in compliance with the applicable provisions of the Administrative Procedure Act (Gov.Code, §§ 11371-11427, inclusive) and otherwise to conduct the proceedings consistently with the views expressed in this opinion.

PIERCE, P. J., and JANES, J., concur.

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